S. HRG. 103-576

HEALTH CARE REFORM

 RINGS

BEFORE THE

COMMITTEE ON SMALL BUSINESS
UNITED STATES SENATE

ONE HUNDRED THIRD CONGRESS

FIRST AND SECOND SESSIONS

ON

FIELD HEARINGS ON HEALTH CARE REFORM

DECEMBER 9, 1993, JANUARY 20 AND 21, 1994

Printed for the Committee on Small Business

U.S. GOVERNMENT PRINTING OFFICE

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DECEMBER 9, 1993

LITTLE ROCK, AR

HEALTH CARE REFORM

THURSDAY, DECEMBER 9, 1993

U.S. SENATE,
COMMITTEE ON SMALL BUSINESS,
Little Rock, AR.

The Committee met, pursuant to notice, at 9 a.m. in the Hershel Friday Courtroom, University of Little Rock Law School, Little Rock, AR, Hon. Dale Bumpers (chairman of the Committee), presiding.

OPENING STATEMENT OF HON. DALE BUMPERS, A U.S. SENATOR FROM THE STATE OF ARKANSAS

The CHAIRMAN. Good morning. I am going to keep this hearing on time today. We have enough witnesses to take us well into the afternoon, and maybe even evening. So it is important to other witnesses who will be coming to testify later that we be ready for them when they get here. First I want to thank all the witnesses. I apologize for my voice, but it is much better than it was. I thought for awhile I was going to have to cancel this hearing. I want to thank all our witnesses for the time they spent on their statements, and more importantly for their concerns about health care and health care reform.

The primary purpose of this hearing is to hear the concerns of small business owners about the impact the various health care plans will have on them and their ability to continue in business. But we would be remiss if the Committee did not also hear from providers, consumers, the insurance industry and others, simply because we cannot evaluate the small business impact in a vacuum. We need to know more about how the plan is going to affect ordinary citizens, the States, those presently self-insuring their employees, the public health clinics and myriad other questions.

Is the present definition of small business, 75 employees, a proper level or should it be higher? Should every citizen have a right to a doctor of his choice? The health care costs have skyrocketed to the point that we now know that in the past 25 years it has consistently doubled and quadrupled the inflation rate.

A few statistics to illustrate a point. In 1980 health care spending represented nine percent of our gross domestic product. By 1992 that number had increased to 14 percent and it is expected to rise to 18 percent by the year 2000, almost one out of every five dollars we spend in this country by the year 2000, if we do nothing, will be for health care. No other country in the world spends more than 10 percent of their gross domestic product for health care. We could

very conceivably be spending twice as much per capita or a percentage of our GDP as any other nation on earth.

This year the United States will spend as much on health care as we spend on the combined cost of all fuel oil, natural gas, electricity, gasoline, transportation, including all new and used car purchases, furniture and household equipment. Health care spending for each worker in America will cost over $7,000 in 1994. Without reform the cost per worker will increase to $12,386 or 25 percent of their total compensation by the year 2000.

Insurance premiums and Worker's Compensation payments by employers have increased over 200 percent after inflation over the past 20 years, and for many small business employers, the cost of coverage is now beyond their means.

One item proposed in the administration's plan and universally applauded is to cover the medical portion of Worker's Compensation under the new plan.

The President deserves a lot of credit for taking on this very difficult task of reforming the system. It is universally agreed that this has to be done.

Next year the Congress will consider essentially four proposals, there will be many on the table, which represent widely different approaches to expanding health care coverage and controlling costs. Some will simply provide for tax incentives to encourage private coverage, others, notably the Clinton plan, will mandate that employers provide benefits. I might add that this is an item that drives small business up the wall. Some will institute a single payer national insurance system, similar to Canada's.

I cosponsor the President's bill with the clear understanding that it will have to be amended extensively before final passage. While I support the goals of the administration's proposal, I also recognize that there are many different ways to achieve those goals. No approach will be painless. There is no magic bullet. Our challenge is to find the right balance between short-term pain and long-term benefits.

Because this issue is so important, I want to stay in close touch with the people of our state as the Congress begins this work. Today is the first of a series of hearings I plan to hold throughout the state. Because of the large number of witnesses, I have asked them to limit their testimony to 5 minutes so we will have more time for questions and answers. I recognize that given the complexity of the health care issue, 5 minutes is woefully inadequate and I appreciate the effort all of you have taken to prepare very thoughtful statements, most of which I understand. The President's proposal alone is over 1,300 pages long. Four other comprehensive bills have been introduced just during this past session. So, I do not expect anyone to be a consummate expert on these reform proposals. All of us simply use our deep and abiding concern for what is best, not just for each of us, but for our country and for the people of Arkansas. In doing so, we need only use our common sense, based on our practical experience in arriving at our conclusions.

Finally, I would like to point out that 85 percent of the people in this country have health care coverage of one extent or another. Roughly 37 million have no coverage. They represent about 15 percent of our population who have no coverage. Of the 85 percent

who do have health care coverage, a vast majority of them are unhappy with the system. Many of them are apprehensive because even though they may have a quarter million dollars in the bank, they know that even in the best of circumstances, that could be wiped out under today's system.

In addition to that, they are not always satisfied with the efficiency of the system. There is this fear, and everybody champions what the President is trying to do but it is the President's and Congress' responsibility to convince these people that what they are going to get is better than what they have got. Unless we are able to do that, this reform is going nowhere. You cannot ask people to give up a known quality and a known quantity for something they do not really understand. When you look at the 1,300 pages of this proposal with as yet no real summary with illustrations answering the thousands of questions that people have, obviously we have our work cut out for ourselves. Not only from a substantive standpoint in drafting a really substantive new health reform bill, but also in convincing the American people that they are going to be better off with it.

On our first panel we have Representative John Miller, my long time friend and chief aide when I was Governor of the State of Arkansas. He is a co-vice chair of Arkansas Health Resources Commission. And Dr. Drew Kumpuris, chairman of the Governor's Task Force on Health Care Reform. If someone were to introduce one of my sons as Senator Bumper's son, he would be offended, but he is Frank Kumpuris' son. We welcome both of you and we thank you very much. John, since your name is first on my list, would you please proceed?

STATEMENT OF ARKANSAS STATE REPRESENTATIVE JOHN E. MILLER, DISTRICT 67

Mr. MILLER. Senator Bumpers, thank you very much. It is a real honor and a privilege to be here and to attempt to advise you on things that you know much more about than I do or ever will know about, so do not take what I say as trying to tell you that I am the authority on this issue.

The CHAIRMAN. There are no authorities, John, do not apologize.

Mr. MILLER. But, as you know, I am deeply concerned about providing adequate health care. I remember very well that the first time I met you was when you were signing up in the Secretary of State's office to become our Governor.

The CHAIRMAN. Do not say how long ago that has been, John.

Mr. MILLER. I am not going to talk about that, because I had already been in politics awhile. So I sure do not want to let that get out.

The next time I really visited with you at any length was in my family's store in Melbourne when you were up there campaigning, and I was impressed and have always been of the depth that you go to try to learn about the needs of people all over this state, particularly in the rural areas. One of the subjects that we discussed that afternoon in Melbourne, Arkansas was the need for doctors out in the rural areas, and you have been a champion of that ever since I have known you. I do not know what your ideas were before I

learned of you. I have always been impressed with your wife and the efforts that Betty has made in the immunization of children. I guess if we are talking about trying to save money and deliver quality health care, the first thing we have to do is try to prevent illnesses and try to prevent disease.

The CHAIRMAN. John, let me interrupt you just a moment to pay tribute to Betty since you mentioned her. She is more deeply involved in immunizations now than she has ever been.

Mr. MILLER. I do not know how she could be, hardly.

The CHAIRMAN. And she has been attending seminars all week. As you know, in the last 2 years, she and Rosalyn Carter have had a program called Every Child by Two. Children cannot start school until they are immunized, and there is no problem immunizing children before they start to school. That is not the problem. The problem is how do you get these infants immunized? She and Rosalyn thought they had an idea. They did have a good idea. It is not just their efforts, there is a national awareness.

Yesterday morning at breakfast she told me we have not had a measles case in 3 weeks. Unprecedented, unheard of. So far this year, I do not believe we have had a single death due to measles, and the incidents of measles is going to be by far the lowest in this year in the history of this country. In 1990, we had 27,600 cases of measles and 32 deaths. Absolutely every one of them was preventable. But you think of the cost of treating those children, you think of the man hours lost with parents staying home with sick children. And the only reason I mention that, John, is to pay tribute to Betty because she has worked so hard on it. I will also say most of these problems are solvable, we have the determination to attack. I apologize for interrupting. Please proceed.

Mr. MILLER. Well, I am glad you did because I feel so strongly about that issue that I was talking to the executive director of the Arkansas Health Care Resources Commission, and told her about Betty's activities regarding immunization. And it has distressed me the last few years because there have been times that we have said the money was not available to buy the shots to immunize these children. We all know that that has to be our number one priority.

Another thing that is very important, and you addressed it when you were Governor, in fact, you addressed about all the issues that I know of when you were Governor, so I am not telling you something that you do not already know and that you have not already addressed. I am only trying to remind you of those things and let you know that there is support out here for these kind of things. And in the early 1940s—is that a time limit?

The CHAIRMAN. That is a Washington system, John.

Mr. MILLER. Okay. We were admitting 89 and 90 students to medical school, which was on this ground here, this was the campus of the medical school. And that continued on at least until your administration, when we addressed that program and Senator Howell, myself, others and you tried to educate more doctors, to make doctors more available. We now have that program up to 150. And that is one of the things that I think that we must do in order to make health care available to our citizenry.

Another issue is the nursing program. We have established the One Plus One program. I do not know how familiar you are with

the program, but we will discuss that any time you want to. I think I can explain One Plus One in detail—it is making quality nursing more available to the public, and we are not having to go to the Scandinavian countries and sign contracts to get nurses in this country.

I will try to cut my testimony as short as I can. Of course, I am such an admirer of yours, that I would like to just sit down and have a two or three——

The CHAIRMAN. In that case, take all the time you want.

Mr. MILLER. Two- or three-hour discussion on the issues of the day. But, as you know, we are attempting in this State, to address the needs of health care cost. There are so many issues that we can get involved with, but I will go down to the end of my prepared statement.

We specifically encourage your position on the Health Security Act to reflect its impact on state government. We think the Act should include every American, assure the opportunity for Medicaid waivers, allow State control of Alliances and governing bodies, provide funding, preventive care and public health services, and simplify administrative procedures.

There is only one other thing that I must mention, because it has made health care so much more available in rural areas of Arkansas, and that is the AHEC program. You are more familiar with it, I do not think any more familiar, but I think I have learned from you and know about that program in very much detail now. If we could establish the AHEC system all over this country, it would do wonders to make health care available to more rural Americans, and if we can get the medical profession disseminated out in the rural areas, I think it would be cheaper.

Thank you very much.

[The prepared statement of Mr. Miller follows:]

PREPARED STATEMENT OF JOHN E. MILLER, ARKANSAS STATE REPRESENTATIVE

Senator Bumpers, on behalf of the Arkansas Health Resources Commission, I sincerely thank you for giving us this opportunity to share some of our goals and thoughts on the future of health care in Arkansas. Today, I'd like to address health care reform efforts in Arkansas, past and present, and functions of the Health Resources Commission.

Our commission was formally authors during the 1993 Arkansas Legislative Session in response to escalating health costs to our State government and ultimately to our citizens. Individuals appointed as commissioners have pledged to study areas of potential concern that could result in legislation to improve the health status of Arkansas citizens, and make the process of obtaining health care more affordable for all.

The 23-member commission is comprised of a group of the most experienced legislators in our State; heads of the major State agencies involved with health care administration; and several esteemed medical industry professionals who have special expertise regarding the key segments of health care in Arkansas. I'd like to introduce some of these commission members here today: Mr. Bob Eubanks, a partner with Mitchell, Williams, Selig, Gates and Woodyard, and Mrs. Betty Bohannon.

I need to emphasize that this commission was formed before President Clinton made public his national health care reform issues and introduced the Health Security Act. Our commissioners are out studying many of the same issues as proposed in the Federal Act simply because they are present in Arkansas. I know you are well aware, Senator Bumpers, we have been producing legislation for years that has improved rural health care, increased the availability of medical providers in our State, and attempted to regulate unnecessary medical technology. We certainly haven't solved all the problems, but we have taken action and I'd like to remind you

of specific legislation we've enacted, much of which you participated in as governor of Arkansas.

One of the first things we did was to recognize that the best way to decrease health care cost is to make health care available to all our citizens. We realize that health care economics does not follow standard business economics and that increased capacity may increase usage and cost. However, it is only common sense to many of us that without health care providers being available in our rural areas, it has to cost more to provide care there. We have to increase the supply of medical professionals by increasing the capacity of our training programs. We can save health care dollars by ensuring that the medical professionals we train are highly skilled to better diagnose and treat illness in the best, most cost effective manner, without having to rely on numerous unnecessary tests and procedures.

Therefore, Senator Bumpers, with your help as Governor, we vigorously pursued increasing the sizes of our medical training programs through legislative action. As a matter of history, in 1967, I was joined by Senator Max Howell in introducing legislation that increased the size of the entering classes at the University of Arkansas for Medical Sciences Medical School to 122 students. In 1977 and 1985, legislative action again increased the openings for entering medical students, to 136 entering students and then to 150 students, where it stands today.

Next, the creation of our Area Health Education Centers (AHECS) in 1973 stands out in my mind a great example of the joint efforts of by yourself, State lawmakers, administrators and University and Medical Society visionaries. The AHECS are furnishing up-to-date health care services closer to our rural populations, given opportunities for family practice medical residents to train in more rural and primary care settings, and arranged for continuing education services to medical providers already located in rural areas. The centers are still one of the most successful medical programs nationwide and are celebrating their 20th year of operation in 1993.

You also participated in legislative actions in Arkansas to extend practice acts. If we have trained medical professionals, such as nurse practitioners and physician assistants who are capable of providing care at a much higher level than they are allowed, it also goes without saying that we are going to increase the availability of health care to our communities and save costs. Though we had to fight to offer extended authority to these professionals, there is still more to be done, both nationally and at the State level to allow nurse practitioners and physician assistants to practice independently and to prescribe certain medications. We do have to provide increased training opportunities for physician extenders in Arkansas, but until we offer them the practice guidelines they deserve, it will be difficult to recruit all the students we need.

We have been successful in another area of nursing training. My good friend from El Dorado, Senator William D. Moore, along with Representative Lloyd George and myself submitted successful legislation that provided opportunities for nurses to achieve career progression. This legislation was drafted to address, among other things, the problem of attrition from the nursing field. It opened the way for licensed practical nurses who knew they like nursing and wanted to continue as professional nurses and qualify for academic upgrade programs allowing them to become registered nurses in 1 year. The program at the satellite campus of the North Arkansas Community College, located at Batesville, offered the first of these programs in the State. They are graduating another 24 students this month and have had 100 percent of their students pass State nursing board exams in their 8-year history of operation.

These are just a few areas where we've worked through State legislation and in response to Federal mandates to our health care resource needs by increasing training programs and ultimately improving health care in our State and lowering health care costs.

Another key area of health reform that Arkansas has already addressed is insurance reform. In 1991, then Governor Clinton signed into law Act 238, The Minimum Basic Benefits Insurance Act, or "Bare Bones" Insurance. I'm sure that you're aware that this act was passed in response to a concern on the part of then Lt. Governor Jim Guy Tucker and private citizens as well as small to medium business regarding the affordability and accessibility of health insurance.

The act set out minimum coverage required to be offered by health insurance policies specifying number of days of insurance coverage, a basic level of primary and preventive care, a mandatory offering of coverage for prenatal, obstetrical care, and children's preventative health care, newborn children coverage, and annual and lifetime benefits. Also included were restrictions on pre-existing conditions waiting periods, and prohibitions against cancellation due to medical history, new or extended exclusions at renewal and new waiting periods at renewal. In addition, there would

be continuation of coverage guarantees provided when employers change insurers, when workers change employers, and when insurance companies leave the market. Additionally, the law included restrictions on premium ranges and rate increases, and State mandated benefit waivers were included. Basically, this insurance was designed to be a low cost alternative to major medical insurance that would offer minimal coverage, and by law, be offered to those previously uninsured.

The Insurance Commissioner then proposed an advanced rule to implement this legislation calling for 15 days of hospitalization, 5 office visits per year, a zero annual deductible, an insurance copayment of no more than 20 percent, a waiting period of no more than 30 days from the effective date of coverage for pre-existing conditions and a requirement that all policies comply with statutory requirement of continuation and conversion rights.

Initial hearings by the Insurance Commissioner on this law indicated that the basic benefit package proposed would be beyond the financial abilities of the intended population. The basic benefits were lowered at least twice more, still due to the cost of the insurance as well as the lack of interest by the insurance industry.

The amended regulation provides for 15 days inpatient hospitalization coverage each year, 2 office or clinic visits per year subject to a copayment by the insured of 30 percent, an insurance copayment on covered services and charges of 30 percent. The amended rule also provides for an annual deductible for inpatient hospitalization and outpatient surgery of $500 each year per covered person, with a maximum deductible of $1,000 for each family per year. The waiting period for pre-existing conditions was changed to allow exclusion for up to 6 months before the effective date of coverage.

Notices were mailed to nearly 55,000 employers throughout the State of Arkansas. To date, only one insurance company has chosen to offer the coverage and though 189 applications were received as of late October 1993, only 64 policies have been issued. Our conclusion at this point can only be that even with insurance reforms, without a managed care type of concept or other means to lower costs of high dollar items such as hospitalization and professional fees, the citizens we hoped would benefit from such coverage still find it unattractive.

There are other areas of legislative initiative where we've attempted to deal with health care reform issues, but I won't address them all today. However, I would like to recognize the outstanding work of our State administrators and State agencies in identifying health related needs and taking action, either by policy or by providing direct care. For example, our Department of Human Services Division of Economic and Medical Services which administers the Medicaid program is putting the finishing touches on an electronic claims program called the Automated Eligibility Verification Claims System (AVECS). This program, which I'm sure you've heard about, is a national model for automated claims processing and will make Arkansas the first State to have a paperless Medicaid claims system. Our Medicaid program has also obtained a waiver to develop a managed care gatekeeper program and is now in the process of soliciting physicians who are interested in serving as Medicaid primary care gatekeepers. This office has also recently participated in internal management reviews and is developing more proactive management policies in their administrative oversight of the Medicaid program. We do feel that some of the Federal requirements in our Medicaid program limit us from doing things that would save money and increase coverage. While we are willing to make "paradigm shifts" in approaches to Medicaid management such as consideration of Medicaid privatization or other innovative programs, we are acutely aware and cautious of any change that may effect Federal Medicaid matching funds.

Our Department of Health is also an impressive group of innovatively minded experts and professionals, and I want to specifically single them out for recognition. They, like you and I, and many of our State lawmakers, do not think of what they do in terms of health care reform. Instead, they address problems that need fixing and systems that can be improved and they constantly attempt to anticipate those needs. For example, the pilot and ongoing programs they oversee rival operations in any State in regards to rural health access programs, public health programs, and health statistical analysis. I know that you join me in recognizing the efforts of some of the professionals involved in these past activities that are now described as "health care reform." In fact, Mrs. Bumper's contributions to our State and now national immunization programs are well known and we appreciate her efforts, as well.

The Arkansas Health Resources Commission was formed to speed up the process of looking at how we use our State health resources considering some of the work already in progress. In doing so, we are trying to maintain an awareness of complimentary health care reform activities so as not to duplicate efforts of other govern-

ment groups. Governor Jim Guy Tucker has very similar goals. In supporting formation of this commission, he has continued to encourage the opportunity for dialogue and broad consensus on health care reform issues in Arkansas. So, please let me address the current, and hopefully future, work in Arkansas that is appropriately labeled as health care reform.

Governor Tucker has recognized the need for major players in the Arkansas industry to become involved in any reform discussions from the earliest point in time. He appointed the special Task Force on Health Care Reform to specifically recognize special interests groups and invite them to gather to discuss areas of mutual concern regarding national and State health care reform efforts. Dr. Andrew Kampuris, who, as you know, was invited to participate in health care reform issues at the national level was appointed chairman of this group. The Task Force, working with a Roberts Woods Johnson grant for state reform initiatives, has assembled a highly competent staff and some of the brightest and best minds in health care in Arkansas. In groups of subcommittees they are addressing, among other things, the areas of information systems and data needs, and feasibilities of health alliances for small groups, state employees and teachers, Medicaid recipients and small employer health insurance group purchasing. They are looking at alliances for all Arkansans to include governance, authority, administration and makeup. The Task Force is also addressing malpractice reform, recommendations to provide adequate health care coverage for children and infants, the effectiveness of regulatory constraints on health care such as rate regulation, certificate of need legislation and technology assessment boards. In addition, they have taken on an assessment of appropriate health manpower resource to identify roles for alternative providers in Arkansas health care.

The Task Force's written plan suggests that they are asking for their superb consultant group of Ph.D. economists, statisticians and policy analysts to assist each of these study groups by modeling the costs and impact of each of these positions, including dissenting positions. Once position papers are developed and presented to the Governor, public hearings may be held, with final consensus an end result.

Though I'm aware of some of the early conclusions of Task Force members, I'm sure that Dr. Kampuris and Governor Tucker would prefer to share those with you directly, either during today's hearings or during your next visit with us. I would just like to comment that the Health Resources Commission has been very impressed with the scope of the work the Task Force is addressing and the quality of results the expert members, staff and consultants are producing. We are very eager to begin sharing efforts with the Task Force as we begin our work on continuing Arkansas' health care reform.

In addition to the special Task Force, several committees in the legislature address health care issues. Senator Jerry Bookout, chairs the Joint Interim Committee on Public Health, Welfare, and Labor. This committee and many specialty subcommittees are addressing a variety of topics. They are addressing topics ranging from requiring galactosemia testing for infants to reviewing a proposed merger of the Arkansas State Mental Hospital with the University of Arkansas for Medical Sciences. The need for an Arkansas Tumor Registry has also been addressed, however it appears that the Center for Disease Control may be proposing Federal funding for all States for this program. We applaud Federal funding of this necessary program in all States, and of course, in Arkansas. The Public Health Committee has also discussed the role of physician extenders and recognizes the need for legislation to be crafted that addressed practices of nurse practitioners and physician assistants. Review of regulations for the Health Services Commission is also being conducted. You probably recall that this commission is the vestige of certificate of needs laws for health care in Arkansas, and currently certifies only long-term care beds. We currently are maintaining our moratorium on addition of any long-term care beds in Arkansas due to overall low occupancy rates. Finally, pharmacy issues have been discussed in this committee, including a proposal to require posting of prices of prescription drugs, especially those most commonly used or the most expensive.

The Rural Health Subcommittee of the Public Health Committee is considering ways to improve primary medical care to rural areas including: sending more medical students to rural areas for training, studying the need to increase size of the medical school, studying the need to increase incentives to physicians choosing primary care or family practice medicine, considering the need of the AHECS to expand into more rural areas, and studying proposals to increase the utilization and availability of allied health care providers.

A Subcommittee on Oriental Medicine has been formed to determine if this industry needs regulating in Arkansas. A Welfare Reform Subcommittee is considering requiring immunizations or EPSDT screening to receive welfare payments. They are

discussing AIDs prevention and possible needle programs for Arkansas, and necessary pre-natal care for mothers, especially those with alcohol or drug problems.

The Medicaid Prescription Drug Subcommittee of the Public Health Committee has been reviewing methods of preauthorization for Medicaid prescriptions for certain high-volume and highest prescription drugs. This action is expected to save Medicaid money as physicians will prescribe lower cost medications to avoid pre-authorization hassle, or will be disapproved unless sufficient justification is provided. However, it must be emphasized that the physician still has the option of prescribing his or her drug of choice with adequate justification. This program is required by the Federal Government for Medicaid programs.

The Infection Control Subcommittee has been listening to discussions on requirements for providers to notify patients of the provider's HIV infection. The Arkansas State Medical Board policy currently requires physicians to notify their patients, while Dental Board policies follow Center for Disease Control guidelines, in not requiring notification.

A subcommittee to study the effectiveness of programs to reduce teen pregnancy, infant mortality, drug addicted babies and children without proper immunizations has been formed. Though we do not know the direction this group will take, we were all encouraged by last week's report from our Department of Health of the decrease in teen pregnancy rates in Arkansas for last year. I'm sure the Department of Health folks will provide you more detailed information on that good news.

A subcommittee of the Legislative Council is addressing health care reform issues. The Hospital/Medicaid Subcommittee addresses ways to reduce Medicaid costs. An independent legislative study committee has also been formed to look at the feasibility of combining the State Employee and Public School Personnel Health Insurance Programs. Our State employees are currently self-insured and funded at a contribution per employee, costing the State approximately $220 per month per employee for premiums, which amounts to 71 percent of the employee's premium. For similar coverage, public school employee's insurance provided by Blue Cross Blue Shield varied as to personal contribution, according to school district policies, but averaged only 32 percent. Combining these two groups could result in our State's first health alliance.

A variety of other legislative studies have been authorized, ranging from regulation of confidentiality and disclosure of health-care information, prohibiting denial of medical care to older persons based solely on age, study of a statewide trauma system and a proposal for an Arkansas Universal Health Care Plan. The work on these studies is still very preliminary, and we hope to have more to report during your next hearings in Arkansas.

In addition, since health care is such a big chunk of our State dollar, many other groups address this topic in the course of normal business and I won't even attempt to describe every group or comment here. I will recognize the commission for Arkansas' Future which is looking at the application of benchmarks to State agencies and State government as a way to measure their performance, and State health agencies are included in their agenda. I will only discuss these other groups if you have a particular interest, Senator, and believe I have addressed most of the major issues currently being considered.

The Arkansas Health Resources Commission will endeavor to keep the "big picture" of health care reform in our State and offer to coordinate efforts of all these groups. We can accomplish this purpose as well as the opportunity to step back to view our entire health care system, because of the advanced efforts of Hillary Rodham Clinton and her task force at the national level. We recognize that there are many opportunities to streamline our health system, both by Federal and State governments. These include simplifying administrative procedures, funding for medical student educations, increasing responsibility and autonomy for physician extenders and advanced practice nurses, and trained clinical pharmacists, and providing training and jobs in our rural areas in local health care systems, as I've discussed. We also have opportunities to continue to implement critical public health and preventive health programs which will result in saved health dollars in the long run as well as better treatment for our citizens. We would also like to see improved consumer education regarding available health care services. We would like to try innovations in Medicaid to ensure medical care is accessible to our most needy population, without risking loss of funding from the Federal Government.

How will we accomplish these goals? The Arkansas Health Resources Commission will be looking at the way we spend State health care dollars to determine which areas can be improved. We will be reviewing contracts financed with State money, the future of our Medicaid program, recruitment and placement of primary care providers in underserved areas of our State, as well as other special interest items

we identify requiring improvement. Throughout, this process we will evaluate the current use of State funds for health care by various agencies, boards and commissions, as well as the missions of these groups, as I've discussed. Finally, we will focus on the overall structure which will be used to manage Arkansas' reformed health care system.

We are highly interested in the tenants of the Health Security Act and would like to see many of its provisions implemented. We are impressed with the work that has been put into developing the Act, as well as the importance of addressing these issues. National health reform is likely to integrate Medicaid with health care programs for other citizens, but such changes will be phased in throughout the decade. Though Arkansas is not a large State, we still have an estimated 380,000 uninsured citizens under the age of 65, based on percentages developed during 1990 studies. Other studies have suggested that while some of these individuals choose to be "self-paying," over 20 percent are children, and many are low-salaried working adults whose employment does not provide medical benefits. If any State plans to cover these individuals in its Medicaid program, as Tennessee is doing, significant additional revenues will be required. Our Medicaid program already has cost over $1 billion in State fiscal year 1993 to provide health care to only 341,806 of 361,533 eligible recipients, at an average cost of about $3,000 per recipient. Covering the same percentage of uninsured Arkansans at the same level could have cost an additional $1.1 billion in this year. I do not believe that the State of Arkansas can provide this level of increased funding on its own. In addition, because some of our rural counties are populated primarily by indigent and elderly, or indigent, elderly and corporation employees, I am concerned about our ability to realize the benefits of managed care's lower costs if major elements of the "risk pool" are exempted.

Therefore, Senator Bumpers, we specifically encourage your position on the Health Security Act to reflect its impact on State government. For example, we think the Act should:

1. Include every American in the program.
2. Assure the opportunity for State governments to apply for Medicaid waivers and encourage timely decisions on waiver applications.
3. Allow as much control as possible at the State level for alliances and governing bodies for health care.
4. Provide adequate Federal assistance and funding to States for preventive care, public health services and maternal and child care, including school-based services.
5. Simplify administrative procedures.

You probably noticed that I haven't tried to dazzle you with statistics today. I leave that to our highly competent State agency folks and advocacy groups who collect that information, and to the Governor's Task Force on Health Care Reform, which is doing a fine job of thoroughly analyzing the possible impact of the Health Security Act on Arkansas. Our commission will continue to work closely with all these organizations and groups as Federal legislation advances and we develop proposals and innovations for the long-range plan of implementing changes in Arkansas' health care system. What I have tried to do is to remind us of the progress we've already made, look at where we are today and state the position of the Arkansas Health Resources Commission for the future. If we are invited to future hearings, I believe we can provide more information on our forthcoming discussions of the direction we see for Arkansas health care reform.

Thank you, sir, for your invitation to us today. I have been honored to testify before you and would be glad to entertain any questions.

The CHAIRMAN. Thank you very much, John. Dr. Kumpuris?

STATEMENT OF DR. DREW KUMPURIS, CHAIRMAN, GOVERNOR'S TASK FORCE ON HEALTH CARE REFORM

Dr. KUMPURIS. Thank you, Senator Bumpers. I welcome the opportunity to come before you today and to review with you perspectives on health reform in our State.

To use your example about measles, just to elaborate on it, in 1980 the Centers for Disease Control in Atlanta estimated that there would be 500 cases in 1990. As you said, there were 27,000 reported. The ratio of reported cases and real cases is four to one, so there were really over 100,000 cases, 1,500 hospitalizations and

32 deaths. We now have almost 56 percent of our children who are fully immunized. We have one in four of our pregnant women who see a physician before the last term of their pregnancy. We had the 26th best infant mortality rate in the world. Now, for the richest country in the world, that is simply not sufficient.

One must question and wonder where we went wrong, where we jumped the track, what happened to our health care delivery system. Clearly the things that are wrong with our system right now did not just happen. They have been allowed to happen and we have had an erosion of the health care delivery system and access system within this country for a long time. Much of the health care reform effort that is now underway in Congress is driven by dollars, because of the expanding cost of health care and the increasing percentage of our gross domestic product that it consumes.

But what we are faced with is high cost health care and a situation in which the very underpinnings of our health care delivery system has been allowed to erode to the point that it simply is not adequate any longer.

The current watch word in Washington is "managed competition." Clearly the proposal that President Clinton has proposed is a very managed competition with considerable stress on regulation. As opposed to Representative Cooper's, which is more of a Jackson Hole type of delivery system. But no matter how you look at managed competition, if you go back to the original articles by Coni and Heinfelten, and a good one appeared in the New England Journal of Medicine about 2 years ago, they identify nine states in which the demographics of managed competition may not work. Arkansas is one of those. The reason that managed competition may not work here is because of the sparsity of our population and the high incidence of indigent minority populations, underserved and poor populations.

Our state is high on everybody's list in any type of restructuring or situations in which true managed competition simply may not be the system that works best without considerable thought on how it is implemented and how it is set forth in the rules that we go by.

Now, the problem that we have is, if you go back to the original concerns about delivery and access, we are woefully needing in delivery and access in some parts of our state. My major concern is not where we are right now, it is not where we are going to be about 10 years from now, it is the transition between how we get from where we are to where we are going to go. Clearly I think most people would agree that there is a desire to improve access and improve delivery at a reasonable cost. If the cost considerations outstrip or outpace the improved delivery and access considerations, then the result could be that within our state, we lose the infrastructure that is already present in the forms of rural health providers, people who are providing services for indigent populations, evolving populations and small community hospitals, that we will need to provide that health care once the system is up and running.

Many of those small town doctors and those small hospitals are barely making it. If you look at hospitals as an industry, the returning cost of that group is fairly good. But if you look at some of

the small hospitals in our state, it is not that way. So, we have to be very selective and very caring in nurturing those systems that we need to preserve.

If we see an implementation of premium caps, all payer system type of reimbursement, price freezes and a ruling against physicians using balanced billing, demand on balance billing, what you may find is that small rural providers and providers who go in to the underserved populations, which are abundant in this state, will be driven out of business. So, it is conceivable that 5 years from now we will be trying to figure out how to put a hospital back into a rural community that used to have a hospital because it simply could not weather the storm.

What I would stress would be that there are ways in which we need to have improved access to capital and increased funding of the infrastructure. This means bricks and mortar and equipment. It is interesting that on my way over here, the meeting that I attended at St. Vincent prior to coming to this meeting this morning, was with a high powered price consultant who came to our hospital to tell us how to position ourselves for health care reform. He told us that the place you do not want to be in a capitated system is with bricks and mortar and equipment.

The CHAIRMAN. Say that again, Drew.

Dr. KUMPURIS. Our high powered consultant just got through telling us 45 minutes ago that in a capitated health care delivery system, which is where we are going as a nation, you do not want to be investing in bricks and mortar and you do not want to be investing in equipment. Yet we need to invest in bricks and mortar and we need to invest in equipment in underserved and older populations. There has to be a methodology. There are some proposed ways of providing access to capital.

You need not look any further than a half a mile to the east of where we are sitting right now, in the east part of Little Rock. The number of health care providers in that community is woefully inadequate compared to the rest of the community. A lot of the problems that those folks have is they simply do not have access to the type of health care that other folks do.

Mr. Miller used the example of AHEC. AHEC is a wonderful program. Over the last 14 years, the only way the AHEC program has been maintained under the previous two presidents who did not fund the AHEC program, was that the Congress put back funding for the AHEC program to keep it going. It was in, and I may have this wrong, I think it was in 10 to 12 states, now it is in 3. Arkansas is one of the only survivors of the AHEC program. But that program has been allowed to die on the vine, and yet that is the type of structure, infrastructure investment that we need.

The problem that we have is that although we have lots of equipment and lots of office space and doctors, it is not allocated correctly. Part of the problems that we are going to have, for example, in rural parts of the communities where it may be difficult to set up a true managed competition or a managed cooperation may be have to be the order of the day. In order to do that you are going to have to invest in buildings, you are going to have to invest in equipment. How do you get the funds for doing that? Somebody has got to come up with the dollars. Are they going to be Federal dollars, are

they going to be state dollars, are they going to be entrepreneurial dollars? Hopefully it will be entrepreneurial dollars, and there should be a reason for doing that, because the people in those communities will now be fully funded and will be reimbursed for providing their care. But it would be nice if there was access to capital for people who were in those areas through the Small Business Administration, through private lending from banks. There are some ways for doing that, which we can discuss if you would like, in which health care providers can borrow money and build a health care network in their communities in order to take advantage of expanded health care coverage.

So, we have to look at our resources and how we are planning to provide access and delivery. It is a major concern. The system right now followed the economic reward pattern of where things were built and how things were structured, they did not follow a pattern of where people's needs were. And you can look at any city, Little Rock, Hot Springs, Pine Bluff, Chicago, New York, every city has the same problems that we do.

But as I read President Clinton's proposal and I look at other proposals, that really is not allowed for. There is not a methodology in which infrastructure development can be provided within communities that truly need it. If I had to think of one deficiency, that is a major deficiency that I see right now.

The CHAIRMAN. Dr. Kumpuris, I want to be sure I am understanding what you said. You are saying that there has to be some kind of an incentive there for what you would hope would be entrepreneurial dollars?

Dr. KUMPURIS. Yes, sir.

The CHAIRMAN. Are you talking about to attract investors?

Dr. KUMPURIS. No, sir. For example, in College Station there are no physicians.

The CHAIRMAN. Is there a public health clinic in College Station?

Dr. KUMPURIS. I do not know.

The CHAIRMAN. Somebody is nodding yes.

Dr. KUMPURIS. St. Vincent has an East End Clinic that is out in that community, so there is access, but considering what the rest of the community has, it is far below that.

Now, let us say that a physician wanted to go, all the inhabitants of College Station have insurance through a universal coverage type of plan, let us say that. How are we going to build a clinic there, put x-ray equipment there, put EKG equipment there? Who is going to pay for it? You have several ways of doing this. The same logic applies for south central Arkansas or up in the Ozarks, where the number of uninsured and the number of indigent populations is very high. You have to provide who is going to go there? Well, you can have insurance companies go there. Now, if they go into those communities, that is good, they make the investment, but you then do not have competition. Then they may direct the competition. So in order for an individual practitioner to go into an area that is high risk, he has to have access to capital. And right now that access to capital is not there.

There have been proposals for setting up pools of funds using the insurance system that we currently have to allow for people to draw upon those funds, then go to the bank using that as the down

payment, making interest to the bank tax free, then using the Small Business Administration to underwrite those types of loans to encourage entrepreneurial investment by individual practitioners into those kinds of communities. But it is not there right now. Without that, it is going to take billions of dollars to provide the access and the delivery system that we currently need to have in order to provide health care in this state.

The CHAIRMAN. One of the things that I do not know right now, and that is the impact. I happen to be a strong believer in public health. I am a product of the school nurse who came to the school and immunized the children. And I think that public health clinics all over southeast Arkansas are absolutely their salvation. I am not sure yet what the Health Security Act does for those folks out there.

Dr. KUMPURIS. That is a very interesting question. Let us look at that, just at the public health clinics. The funding for the public health clinics, and Nancy Kirsch is here and she can correct me or expand on this in a moment, but part of the funding for those programs comes from Federal dollars, for different types of populations that are served.

The CHAIRMAN. Right.

Dr. KUMPURIS. Now, under the National Health Security Act, if those dollars are then shifted over quickly to the big budget for health care, the billions of dollars it is going to take to run our project, then those clinics could find themselves suddenly underfunded and go out of business. The state would then have to come in and support them.

The problem, Senator, is that there will be universal coverage. All the patients who go to those clinics will eventually be full paying customers, therefore you will be reimbursed for care that you provide. But that part of the health care plan might be deferred or phased in. So, if the budgetary restrictions portions of the Health Care Security Act go into effect before the universal coverage portion of the Health Care Security Act—in other words, if they are not paced exactly in a way that when you reduce the budget, the funding for one, you increase the funding for the other, you may find your public health nurses in your public health system in south Arkansas decimated. It will be gone, because the basic funding for it will have been shifted over to different programs.

The CHAIRMAN. Your fear I take it, is if they got thrown into this huge pot, they are going to be like a stepchild?

Dr. KUMPURIS. Yes, sir. My fear is that, and this may not be a pragmatic approach, but I think it is. I think a lot of what we are doing right now is deferring the cost of health care. The terrible problems of the immunizations and everything else that you have referred to and that I have referred to have been there for years and no one has addressed them with the intensity that we are addressing them right now.

What is driving this is dollars. My concern in the interim financing for health care is that the dollars will oversee or overpower the delivery part. We are eventually going to get to good delivery, but the concern about the implementation of price controls, freezes or all payer systems or bans on balance billings or premium gaps—

and those are all efforts to try to plateau that 14 to 18 to 20 percent that you alluded to as a percent of GDP—it seems to me that the administration is going to try to plateau that out while they phase in the improved delivery system.

If you squeeze the dollars too hard, then you are going to hurt and damage providers in the community that you are trying to preserve. What I think the worst result that we could have here is, and not only here, but in every state, would be 3 to 4 years after this effort to try to curb the budget and squeeze the budget, we try to rebuild a health care infrastructure delivery system in these communities that it was already there. Granted, it was not perfect, but there was already a hospital there, there was already a doctor.

You could look in Carlisle, Holly Grove, Lonoke, I mean all the small communities west of here, I added it up the other day——

The CHAIRMAN. East of here.

Dr. KUMPURIS. I mean east of here. There used to be six doctors in those communities, every one of those communities had a physician. Now only Lonoke does and they have lost one of their doctors, so they have two left, the rest of those communities are without physicians. A lot of that is a result of their ability to earn a living in those communities because of rising cost. If you take away, for example, the balance billing ban, it is a good idea for the budget, it is a bad idea for rural providers who are barely making ends meet in small communities, because that may be the difference between them staying in those communities and them folding up their tents and moving somewhere else.

So, as a health care planning group, we are then faced with how can we get a doctor in Carlisle or Holly Grove, when there already was a doctor in Holly Grove that could not make it for financial reasons.

Simply stated, and I have rambled on too much, but my concern is in the transition years, I do not want to see us destroy what infrastructure we have. We need to build on what we have, not let this reform drive squeeze dollars and put out of business the very providers we are trying to save.

The CHAIRMAN. Representative Miller alluded to all the initiatives we undertook when I was first elected Governor. Because I came from a town where we sometimes had one doctor, I was acutely aware of the lack of rural health care. We had the ability to build a new education center out at the Med Center. We were determined to double the number of doctors. We have now just about reached that goal. I think we were taking 80 a year when I was elected Governor, and today it is about 150. But I can tell you we found that that is not a solution.

We provided health care scholarships for students who would go to medical school. Back then it was only $5,000, but I can tell you $5,000 in 1971 was a pretty good hunk of change. But we provided $5,000 scholarships for any youngster who would agree to go back to any community in Arkansas that had fewer than 5,000 people. That was inadequate for the doctor. We found out that the doctors get used to all that expensive equipment, sophisticated assistance, personnel and so on, and they are not going to go to Charleston or Holly Grove, so that was not particularly good.

One of the initiatives we took when I was Governor, and it is still in place and it works extremely well, is AHEC, which both Representative Miller and Dr. Kumpuris alluded to. And incidentally, I had to work like a sabertooth tiger this year to keep Arkansas' program going, because we were about to lose a hunk of money. I just happen to know the program well enough, it is one of those things you just hope that somebody knows enough about it to take an interest in.

But my point is, the situation that I tried to remedy when I was Governor has progressively gotten worse. You mentioned Holly Grove and all those communities, I go into those communities all the time, and the number one problem that they want to tell me about is lack of health care. They do not have a doctor, or have an 80-year-old doctor who is still practicing but is trying to quit. And that is one of the reasons I want to know what impact reform will have. I believe that public health clinics, while it is not an ultimate solution for those communities, is a very good partial solution.

We have some clinics down in south Arkansas that those people love. The most controversial decision I was confronted with during my first year as Governor was a so-called OEO Grant to Lee County for the Lee County Cooperative Clinic. And everybody remembers that it was a very racist thing. I had some 15 State troopers down there to keep order after I signed off on the grant. All kinds of dire predictions were made. And as you know, today the Lee County Cooperative Clinic is the only health care clinic in Lee County. Everybody, whites, blacks, everybody uses the Lee County Cooperative Clinic. It is a real success story.

But I am going to tell you, I am not sophisticated or smart enough or know the health care delivery system well enough to tell you how we are going to deal with that. But I want to make sure that this Health Security Act provides adequate funds, not only for the existing public health clinics in this country, but I think it is a place from where we ought to build.

I saw where the American Lung Association was meeting in New Orleans this week, and I notice they take strong exception to something that a lot of people are talking about now, and that is more care from nurses and nurse practitioners. I happen to disagree with that. I think there is a tremendous amount of care that can be delivered by allied health personnel, do you agree with that?

Dr. KUMPURIS. Yes, sir.

Mr. MILLER. I agree completely, Senator.

The CHAIRMAN. Now the other thing, and I will close with this. I would like for either one of you to comment on the dollars. You know, that is in essence the trajectory of health care cost, it is the impetus of this whole initiative.

I can remember one time when I was first elected Governor, cattle prices just went to nothing. It was a story I heard up in Yellville, the guy said something about I lost $100 this morning. How? He said my cow had a calf. Well, normally cattlemen depend on calves, but they were so expensive to raise, and the price was so low.

This is precisely where we are on health care. You sit in the coffee shop in the morning you start talking about your hospital bill, I guarantee you everybody around that table will one up you

and tell you about how much greater theirs was than yours. That is the thing that is driving people crazy in this country.

There are a lot of people who say there is nothing wrong with the system, "If it ain't broke don't fix it." I do not agree with that. I think that generally health care delivery is pretty efficient in this country. You talk about equipment for a clinic in, say, College Station. This goes back to the early 1970s, Wilbur Mills tried this one time but it never did work terribly well—there is a provision in this bill that the alliance or the carrier that they contract with will not be obligated to pay for any care provided by a piece of equipment the purchase of which was not authorized.

Is that right Maryann?

Ms. CHAFFEE. [Indicated yes.]

The CHAIRMAN. The most salient point I think was an MRI, they are very expensive, and they are extremely effective. We got a new one now coming out, as you know, called PET, sort of a successor to the MRI, which is also very expensive. I remember we tried to confine heart surgery to one hospital in this state, because we just did not feel that we needed more than one hospital doing heart surgery. And unless it is fully utilized it is terribly expensive for everybody to be doing heart surgery.

I look back at all the things that have been tried and did not work, and I can remember when if you wanted to be reimbursed by Medicare, Medicaid or the Federal Government, if you bought a piece of equipment that was not approved, you could not be reimbursed on anything. Now they simply say we will not reimburse you for what you do with that piece of equipment, unless we approve the purchase of it. I can tell you that is not going to work. That is an administrative nightmare.

Now, there is one other thing I might say for the benefit of everybody, and that is, one of the reasons we are not going to go to the Canadian system of having a single payer, much as the way Medicare works in this country, the reason we are not going to do it is principally political. By that I mean there are 1,500 insurance companies in this country who provide health care insurance to one extent or another. There are 300 big time operators in the health care insurance industry in this country. A single payer, under the eases of the Federal Government, eliminates all these people, and they are all pretty big campaign contributors, so I can tell you that is not going to happen. But I will tell you this. And I do not know whether they should or not. The other political part of that is, people conjure up this one big gigantic bureaucracy dictating all health care in this country, and that just scares them to death, understandably. And people like Rush Limbaugh talk about, oh, my God, they will have the efficiency of the postal service and the compassion of the IRS. That always has as much credibility, but everybody believes it so I can tell you that that is not going to happen, but I will say this, and I invite any comments you might have on it. Suppose you had a focus group with 30 people from all walks of life in a room, and you let Senator Wellstone give a presentation on his bill, which calls for a simple single payer system, the Canadian system we call it. Then you invite Mr. Clinton who is articulate, brilliant and persuasive, and you also invite Jim Cooper, Pete Stark or some of these people who advocate a third alterna-

tive, which is sort of tinkering around the edges. And Senator Wellstone's idea, as repugnant as a national bureaucracy delivering all of our health care in this country is, when the focus group hears all options, so far I can tell you that they are opting for the Paul Wellstone approach—the single payer. It is not without merit.

There is an assumption with the single payer, that if you eliminate 300 insurance companies, you are going to eliminate all the profits they make, and that profit can be used on health care delivery. That is nonsense because you do not really make that profit, you simply hire other people who work for the bureaucracy to deliver the same kind of thing. Somebody has to do it, Blue Cross/Blue Shield, Prudential, Metropolitan, somebody is going to do it.

But for all of those reasons, I do not know why I really brought this up since that is not going to happen, except for mine and your edification because it is one of the proposals that is on the table and a lot of people feel very strongly about it. Do you have anything you would like to add to that?

Dr. KUMPURIS. Only to reinforce that, as you said, the rocket trajectory of the rising health care costs is the prime mover behind what we are doing today. But we have to step back and look at what we need in order to accomplish the goal. Do not let that trajectory run over the system that we already have in place, and allow us to protect the hospitals and the providers who are servicing multiple populations, so that we do not have to replace them 5 years from now. That would be my closing message to you.

The CHAIRMAN. Well, Dr. Kumpuris, and Representative Miller, I want to personally thank both of you for coming down here.

Mr. MILLER. Let me tell you there are two other members of the Health Resources Committee here, Betty Bohannon and Bob Eubanks.

The CHAIRMAN. All right. Thank you very much, John, Doctor. I appreciate both of you taking the time to be here. John, I especially appreciate your kind words and reciprocate it totally. You know, I value your friendship.

Mr. MILLER. Thank you very much.

The CHAIRMAN. Our second panel consists of Greg Brown, chairman and CEO of Union Bancshares of Benton, Benton, AR. Tom Murry, owner of Kawasaki Sports Center, Little Rock. Keith Abney, owner operator of McDonald's Restaurants in Roland. Vernon Nelson, president of the Nelson Group in Arkansas. All of these gentlemen are small business people. As I said, that is the principal reason for the Small Business Committee being here, that is to get the input of the small business group. Greg, you are number one on my list. So, please feel free to commence.

STATEMENT OF GREG BROWN, CHAIRMAN AND CEO, UNION BANCSHARES OF BENTON, INCORPORATED, BENTON, AR

Mr. BROWN. Thank you, Senator. If you will bear with me a little bit, I think that any industry which in 3,000 or 4,000 years still cannot cure the common cold, certainly deserves a whole lot of recognition. My voice may go before the day is out.

First I would like to express my appreciation for the opportunity to appear here today. The Democratic leadership in Congress has

stated there will be a health care bill passed next year. We all recognize whatever form that legislation takes, the final Act will have survived numerous committees, the floors of both houses and a conference committee. Hearings such as these I believe are the only viable format in which those who will be most affected by the legislation can have some input separate and apart from the special interests, lobbyists who haunt the halls of Congress.

I am chairman of Union Bancshares of Benton. We are a bank and thrift holding company based in Benton, AR. We own the Union Bank in Benton, a State chartered bank with approximately 95 million dollars in assets. We also own Benton Savings and Loan Association, which has approximately 93 million dollars in assets. Both the Union Bank and Benton Savings and Loan Association operate wholly within Saline County. Benton Savings has one location and employs approximately 27 full-time employees. Union Bank has three locations and employs approximately 45 full-time employees.

I have already detailed our experience with group medical insurance for our employees in my written testimony so I will not repeat that long story here. Suffice it to say that it was no less traumatic for me as an employer who offered insurance to them as part of our benefits package, to have our policy cancelled than it would have been for any middle class family faced with the same arbitrary decision made regarding their family's coverage. I might add, however, that once the coverage we had obtained through a Little Rock agent was in place, our Benton representative from the same insurer advised us that he had attempted to get identical coverage when we had consulted with him. The insurer had refused to even look at it for our local man, but was willing to sell the coverage through a large independent national agency. I do not know what drove the insurer's decision in that regard. I believe it demonstrates another of the anomalies which plague the medical care and insurance complex today.

I have a couple of major concerns about the structure of the President's health care proposal. Whether the costs are on budget or off budget, we must be careful not to create the fiscal black hole which has been exemplified by both the Social Security system and by Medicare and Medicaid. During my adult life I have seen the Social Security tax percentage trebled with concurrent increases in the level of earnings subjected to those taxes. Only a couple of years ago that portion of FICA taxes withheld for retirement was segregated from that portion for Medicare and Medicaid and the entire structure indexed to the CPI.

First, I submit that the vast majority of the American public in my age bracket believe that there may or may not be any money for us when we retire. And second, if there is, it will come from our children's labors and taxes, not from the trust fund which was originally created.

Congress has amply demonstrated its unwillingness to bite the fiscal bullet where results are adverse in the immediate future, but beneficial 10 or 20 years out. We must not permit this demonstrated shortsightedness to lead to the development of a new series of entitlements, which will swallow an ever larger portion of the budget without any review or control.

I recall the gnashing of the medical profession's teeth when Medicare and Medicaid were first being debated. The basis of the complaining usually was that incomes within the profession would be cut. However, we have seen that under the present system, medical professionals are the primary customers of Chenal Valley lots and houses, and I personally heard one doctor state that he could not wait until he was 55 when he would retire. I believe strongly that the free market resolves inequities over time. An entrepreneur who builds a better mouse trap should not be limited in how he capitalizes on that idea. In Arkansas Sam Walton and Don Tyson both demonstrated the value of their unique ideas and drives. However, something is inherently wrong in a system which has become so far removed from being a free market that even mediocre practitioners can demand incomes from a quarter of a million to a half million dollars a year.

I am not smart enough to figure out how to restore some balance in the compensation system for medical care. I like to think I am smart enough to know that between several hundred insurers and thousands of dollars, a way to circumvent intended limitations will be found. Merely limiting the rate of increase of insurance premiums, or should we call them taxes, each year will not be adequate. Where costs and the desire for additional income outstrip the CPI, then the level of care or the quality of care will decrease.

Virtually all of the objections I have heard to the President's plan from small business owners have centered on two points. First, the cost to the business owner, and second the potential effect on the National debt. I have already commented on my fears vis-a-vis the net cost of the program to our government. I know my fears are among those shared by the average small business owner in Benton and Saline County.

Those of us who have chosen to own or manage small businesses in our communities have been subjected to ever increasing pressures from our Federal Government. I am prone to characterize the nature of these pressures as a creeping encroachment. Over the last several years we have sustained increasing cost in our operations from numerous government interests. We have to follow regulations from the Environmental Protection Agency, the Occupational Safety and Health Review Commission, from the Equal Employment Opportunity Commission; we fill out additional forms that have to be filed with the Census Bureau; not to mention the direct cost of increasing taxes, both income taxes and FICA taxes, and decreasing deductions.

It has reached the point that every time we turn around there seems to be a new agency with a new set of regulations we must follow. Although we cannot fault the ideas behind the regulations, we do doubt that they are absolutely necessary to cure the ills they were meant to address. With this track record, I understand my fellow small businessmen and women when they express concern over the cost of providing medical insurance to the Nation.

First, the vast majority of them will be incurring a cost which they have not had to bear previously. It must be noted that this cost will be incurred on the front end, immediately upon passage of a reform act. While it is true that they may realize some savings in the future, either from reduced Workers' Compensation premiums,

from better productivity from their workers, from any area that these savings might come, there are two perceptions which are not subject to be changed. That is the average business owner will view the immediate costs as potential profits that are gone forever. He or she will never have a chance to make these profits back.

Second, any savings from other sources will be delayed and will not be contemporaneous with the increased costs. When, and I dare say if, the savings are in fact realized, they will neither be identifiable as savings related to the health care plan, nor will they be as large as either the White House, OMB, the Congress or CBO promised.

As both a small business owner and as the banker for numerous small businesses in my community, I would urge Congress in the strongest possible terms to work with the administration, to fashion a health care plan which will restore a semblance of free market competition to the field of medical services and the delivery of those services, and which will thereby act as a much better cap on cost than any artificial limitation. I would also strongly urge you to be realistic about the costs to be incurred through any proposed plan and the manner and the amount of taxation necessary to defray those costs. Further, once those numbers have been determined, communicate them to the public without the partisan deficit related subterfuges that have characterized Congressional fiscal commentaries in the last several years.

I believe that the capacity of the American people to support such a worthwhile effort as we are undertaking is immense. However I would hope that we would be able to receive and rely upon realistic expectations during the legislative process. Thank you.

[The prepared statement of Mr. Brown follows:]

PREPARED STATEMENT OF GREG B. BROWN, CHAIRMAN AND CEO, UNION BANCSHARES OF BENTON, INC.

I am Greg B. Brown, Chairman and CEO of Union Bancshares of Benton, Inc., a bank- and thrift-holding company based in Benton, AR. Union Bancshares was one of the first bank holding companies in the country to acquire a healthy savings and loan after passage of FIRREA in 1989. We own The Union Bank of Benton, a State-chartered, non-Federal Reserve member bank with approximately $95 million in assets; we also own Benton Savings & Loan Association, one of only four State-chartered thrifts in Arkansas which survived the 1980s as a healthy institution; it has approximately $93 million in assets.

Benton is the county seat of Saline County, AR; its population is approximately 23,000. Saline County has a population of approximately 60,000. Until the early 1980s, the largest employers in the county were Reynolds Metals and ALCOA; their hourly employees were represented by locals of the United Steelworkers of America. In the early 1980s, Reynolds closed their operation completely, and ALCOA has reduced their employment level to approximately 200 persons. The county's largest employers are now the Benton Unit of the Arkansas State Hospital and Saline Memorial Hospital. Our marketing research has indicated that between 40 percent and 50 percent of the employed population of our county commutes to work in another county with about 90 percent of these being employed in the Little Rock/Pulaski County area. It is only a 20 minute drive up Interstate Highway 30 from downtown Benton to the heart of Little Rock.

Both The Union Bank and Benton Savings & Loan Association operate wholly within Saline County. Benton Savings has one location and employs approximately 27 full time equivalent employees ("FTE"). The Union Bank has three locations and employs approximately 45 FTEs.

Historically, Saline County employers have not been under pressure to provide health care/medical insurance benefits for our employees because so many of our employees had spouses working at Reynolds and ALCOA, who were covered under

their company plans. I personally believe that the local financial institutions were the most progressive in this area, primarily because of the competition from Little Rock and Pulaski County for employees. Most of the employers in Pulaski County provided at least some medical benefits, and in order to retain good employees, Benton's financial institutions also offered some benefits to those employees who wanted them.

From 1987 through 1989, The Union Bank offered its full time employees coverage through a group policy issued by Blue Cross/Blue Shield of Arkansas. During that time, we usually had 30 to 40 employees of our 50 plus work force who desired coverage; the small size of the group limited, somewhat, the insurers offering group coverage for which we were eligible.

From 1987 through 1989, the coverage we offered carried a $200 deductible and a $1,500 stop loss, and was available with either individual coverage or with family coverage. For this period, the total premiums paid Blue Cross, the portion paid by the Bank, and Blue Cross' claims paid under our group coverage were:

	Total Premiums	Bank's Share	Claims Paid
1987	$52,091.07	±$32,000	$90,011.59
1988	$66,981.40	±$39,000	$50,174.00
1989	$60,948.43	±$39,000	$165,219.93

In 1987, my wife, Marilyn, had been diagnosed and treated for Hodgkin's Disease; the total claims for her illness were approximately $50,000. 1988 was a "normal" claims year. In 1989, we had one employee diagnosed with a long-term degenerative disease; her total claims for 1989 were $66,000 plus, and unknown future expenses; we also had one employee with $11,000 plus in claims, and two others with heart surgery.

In late February 1990, Blue Cross advised the Bank that they were exercising their right (reserved in the policy terms) to cancel our group policy at its anniversary date, April 1, 1990. Each of the employees covered under the canceled plan could convert to individual policies, and pre-existing conditions would be covered; however, there was no assurance that new employees could obtain coverage, and even if they could, pre-existing conditions might not be covered. Our concerns were threefold: (a) the Bank faced the possibility of massive resignations, because other jobs were available which provided health benefits; (b) any employee who quit would not be readily replaced because we could not offer the health benefits other employers offered; and (c) the increased premiums for the individual policies would have a significant impact on our employees' take-home pay, or the Bank's earnings, or both.

We immediately contacted the major independent agents in Benton, to see if they could obtain coverage for us; because Blue Cross had canceled our policy, no other insurance company would touch our group. Not a single company represented by an independent agent offered to do a risk analysis; because Blue Cross had canceled, they weren't even interested in looking at our case. Even the Arkansas Banker's Association group, which provided coverage for thousands of bank employees in Arkansas, refused to accept us as a part of their group without excluding pre-existing conditions.

I was personally affected by Blue Cross' decision in two ways: (a) Marilyn was still well within the 5-year risk period for recurrence of her cancer; and (b) had at least three employees who still faced the possibility of incurring ruinous medical charges over the near future. The stress they faced would not only affect them and their families, it would also affect their performance at work.

By the latter part of March 1990, it was obvious that we would not find replacement group coverage easily, and that Blue Cross' termination date was so close that any replacement we might find could not be in effect prior to that termination. Accordingly, we elected to accept the "nongroup", individual coverage from Blue Cross. In order to make this option "affordable" for both our employees and the Bank, we let each employee choose between a $500 or $1,000 deductible (the group policy was $200); we retained the $1,500 stop loss. Our employees split about 50-50 percent between the two deductibles. Notwithstanding the substantial increase in deductibles, the total premium for the "nongroup" coverage for 1990 increased to $63,000 plus, with the Bank paying just under half of that charge. In addition, because our people were covered under individual policies, we could not get a single billing from Blue

Cross. Instead, we had to collect each person's monthly bill to pay from, substantially increasing the workload on our personnel department.

We continued to look for alternative coverage, including looking at various trade organizations, which we might or might not have qualified for membership. Inevitably, the answer we got was, "Blue Cross canceled? No, thanks", or "We'll take a look at it, but we won't cover pre-existing conditions."

By May 1990, I had called on personal friendships in some of the largest insurance agencies in the State, but to no avail. Marsh & McClennan, the largest independent agency in the country, had a Little Rock office. I finally called a friend with them, hoping that with their national size, they could "strongarm" some company into taking a look at our situation. (In March 1990, pursuant to FIRREA, we had applied to OTS for authority to buy Benton Savings & Loan Association, which had approximately 20 employees. We knew that adding them to our 40 covered individuals made a more insurable group. Marsh & McClennan referred us to one of their subsidiaries, Seabury & Smith; they recommended that we wait until the Savings & Loan had been acquired, at which time they could try to cover the full 60 employees.)

Acquisition of the S&L was completed on August 31, 1990; in September, we began to compile all the information necessary to enable Seabury to try to market our group. This process took several months, including getting releases and medical records on our four "problem" insureds. By January 1991, Seabury had a proposal from Nationwide Insurance, which was a hybrid, self-insurance/reinsurance plan. We took their proposal, studied it and its effect on our Bank's and employee's incomes, made some changes in our policies and implemented it.

The basics of what we ended up with are: (a) We now require all full time employees to participate in the insurance program; (b) the Bank supplements the employee's salary by at least the amount of the individual's coverage, and premiums are paid through a Sec. 125 plan, to minimize the net effect on the employee's take-home pay; (c) the employee can elect to obtain dependent coverage, but is required to pay the total cost of that additional coverage (still through the Sec. 125 plan). We started out with more than 60 covered employees, and as of September 30, we have 60 under the plan.

We are provided with a company-wide "stop loss" figure at the beginning of each plan year. This is the amount we expense, setting up a reserve against which disastrous events can be charged; each year this reserve can vary, and any amounts which we carry forward from the previous year inure to our benefit. We knew going into the plan that the initial costs would be high, and that in order to keep total payroll costs in line, our ability to offer raises to our employees would be somewhat limited. Accordingly, we promised our employees that we would pay over direct to them a portion of the reserves which remained at the end of each plan year. In this way, we hope to dissuade them from incurring unnecessary medical expenses; we believe that our efforts have been at least somewhat successful.

	Total Premiums	Bank's Share	Claims Paid
1991	$189,915	±$134,753	$38,048
1992	$269,476	±$186,705	$236,755
1993	$198,440	±$125,951	$82,000

The 1993 data is through September 30; we also have a current reserve balance to pay against claims (or rebate to our employees) of approximately $70,000.

Even if the President's plan amounts to an "added" payroll tax to us as an employer, if we can drop our current coverage, and the new tax is less than $3,000 per employee per year, we come out ahead.

Finally, although the premiums we are currently paying may appear to be high, I would hate to think of what would have happened if we had been covered under a private insurer's group plan after 1992, when we had $237,000 in claims.

The CHAIRMAN. Greg, thank you very much for an extremely well articulated statement.

Tom, you are next on my list, so please proceed.

STATEMENT OF TOM MURRY, OWNER, KAWASAKI SPORTS CENTER, INCORPORATED, LITTLE ROCK, AR

Mr. MURRY. Thank you. Today I come to you with a well rounded perspective on the issue of health care. Ten years ago I worked for a major HMO in town so I understand and believe in the concept of managed health care.

Now, as a small business owner, the issue of health care is closer to home. Although we are insured with an HMO, our insurance costs have gone up 40 percent in the last 2 years. Our premiums are $139 per month for singles, and $372 a month for families.

The CHAIRMAN. Tom, say that again, I was just temporarily distracted.

Mr. MURRY. That is all right. Our insurance premiums have gone up 40 percent in the last 2 years; we pay $139 for singles and $372 per month for families. This represents a major percentage of our bottom line. Furthermore our choice of insurance plans is limited, due to the preexisting conditions that we have among our group members. However I feel very strongly about my responsibility to provide health insurance coverage for my employees and many of them would not have coverage at all if we did not provide it for them. We feel that that is a benefit my people cannot do without.

The dollar cost brings that issue close to home. That is something that I have always been very keen on, but the experience I am about to share with you concerning my wife getting a referral to her specialist in the last several months will suddenly change your perspective.

It was a Thursday afternoon in October when my wife, Michele, 13 weeks pregnant at the time, came down with a very unusual migraine headache. It started with very difficult speech, she could not get her words out properly. Then her vision was blurry, then she had numbness in both legs and one of her arms. I can tell you that it was scary—it was very scary, quite frankly. Therefore we put her in the bed and called her gynecologist, and asked what to do.

They told us if those symptoms persist, go straight to the emergency room. Michele has had migraine headaches in the past, so we tried to remain calm, and we waited a few minutes, and sure enough she started getting her vision back and she could articulate her speech better, so we decided to wait until the next morning to see what happened.

The next morning came, came with vomiting and a very severe headache. Although she could see and articulate, she was still numb in places of her body. It was a very big concern for the husband, you know. So, I called and tried to use the right channels from our HMO. I called our primary care physician to get a referral to a specialist who had seen Michele in the past for migraine headaches. Much to my surprise, I had a hard time getting a referral. I thought it was mainly a communication problem in the primary care physician's office, so I took the initiative to go straight to the specialist's office, with full expectation that I would get the proper referral by the time we got there. When we got there, Michele was vomiting at the doctor's office. I know she is glad she is not here to hear this. Anyway, it was a bad scene.

To my surprise, her primary care physician denied us that referral, insisted that we get back in the car, go back across North Little Rock and let this family practitioner give his opinion before he would give her a referral to the specialist. I was appalled. We did call her gynecologist, and got the proper referral, and subsequently Michele was seen by the specialist, and we spent the rest of the day at Memorial Hospital for dehydration and various tests.

Needless to say, we changed our primary care physician in the coming days, but that was a heck of an experience. And let me tell you, after 2 years of being concerned with the cost of health insurance, suddenly I was about——

The CHAIRMAN. Tell me, I assume this all had a happy ending?

Mr. MURRY. It did, it did. But the point I am trying to make is, I have always been concerned with the cost. If we cut out our health insurance at the Kawasaki Sports Center, my income would go up 20 percent. That is a big chunk. Anyway, this experience I have shared with you changed my opinion quite a bit. Suddenly when the quality of care is in question, I think that is probably going to have to take precedence over cost.

Let me finish by saying, this story should illustrate the biggest concern, that among business owners and citizens alike quality of care is what everybody fears is going to decline if we have reform. The reluctance of our primary care physician to refer Michele to the specialist, maybe because of his attitude or because of the way he was compensated, I feel like it is a combination of the two. If his attitude was right, the compensation may not have been a concern. Lopsided financial incentives for family doctors to avoid referrals to specialists have no place in our health care plan. They are in there in places now. I believe such incentives have to be equally strong ones for the doctor to do the right thing for the patient.

In summary, the new health care plan must address the following concerns. Quality of care: Americans will not settle for second rate care. Patients should have ready access to specialists and appropriate treatment, as well as their family doctor.

Availability: everybody deserves coverage, no matter what their preexisting conditions are.

Choice: basic plans, low premiums and high copayments could be upgraded to more comprehensive plans, based on individual's needs. Employers may be asked to provide a basic plan, while employees are asked to pay for additional benefits, if they want more comprehensive coverage. No matter what plan they are on, the quality of care should never be compromised.

Affordability: small businesses and individuals deserve access to the buying power of large groups.

Accountability: any alliances or regulatory agencies should be reviewed annually for cost effective performance.

Flexibility: not only should an individual have flexibility to change their type of coverage annually, it should not take an act of Congress to modify a new plan to meet the needs of the public. A predetermined course of action should be in place in case the fears of some Americans become reality. We know we do not need another wasteful bureaucratic arm of the Government. I trust we will not.

Finally, peace of mind. As you have mentioned earlier, the success of American health care reform depends on the administration's ability to put to rest Americans' genuine fears generated by bad experiences like I have described earlier. Surely a check and balance system could be utilized to put our minds at ease.

I thank you for the opportunity to testify on such an important issue.

The CHAIRMAN. Thank you very much, Tom. Keith?

STATEMENT OF KEITH ABNEY, OWNER OPERATOR OF McDONALD'S RESTAURANTS, LITTLE ROCK, AR

Mr. ABNEY. Thank you. I am Keith Abney. My wife Marilyn and I are the owner operators of two McDonald's restaurants in Little Rock. I have been in this business since 1974.

The CHAIRMAN. Where are your McDonalds, Keith? I will go patronize them.

Mr. ABNEY. Seventh and Broadway, and 3100 West Roosevelt. I admit that I am no health care expert, but I am worried about creating a Federal bureaucracy to control the health care system in the United States. One only has to look at how Medicare and Medicaid work in order to question this approach. This last year a syrup tax of $2 a gallon was enacted to meet Medicare shortfalls in Arkansas. This tax alone adds an additional $15,000 per year per restaurant expense.

The CHAIRMAN. Are you telling me that cost you $30,000?

Mr. ABNEY. Yes, sir.

The CHAIRMAN. Go ahead. That is a State issue, that is not mine, I am glad.

Mr. ABNEY. But there is only one pie all the pieces have to come out of.

The CHAIRMAN. I understand that.

Mr. ABNEY. Any reform should be based on a free market approach, rather than the Government establishing artificial markets and costs. I understand that the objective of this meeting is not to criticize the Clinton plan. I do understand the goal of providing access to health insurance for all Americans, but I question some of the real world economics behind that proposal.

Each of my restaurants operate 133 hours a week. A normal work week for us is 45 to 50 hours, not 40 hours. I currently employ over 105 individuals and 90 percent of those employees are part-time.

As a responsible employer, I provide health care coverage for my full-time salaried managers. I have a difficult time accepting that I should pay 80 percent of the premium of all employees who work over 10 hours per week. This could become a financial disaster for our organization.

Many part-time employees have health insurance coverage from a parent or a spouse, and simply would rather have higher wages than mandated benefits. However, under President Clinton's plan, neither I nor my employees would be able to choose the best compensation package to meet their specific needs. In addition there is no provision for duplication of coverage in dual earner households or for youth or students covered under another family plan.

The employer mandated approach would directly increase my labor costs. Already the quick serve industry is at a disadvantage because we must pay the full minimum wage, where full service restaurants pay only a portion of the minimum wage and their customers subsidize their labor costs by using the tip credit rule. I am in a highly intensive labor business and labor costs cannot be readily passed along to my customers. Instead I will be forced to make some tough economic decisions, which may include raising the prices of my menu board, lowering actual wages to offset my increased costs, restructuring my work force, and/or creating fewer jobs.

Any health care plan should include malpractice reform legislation and include the health care cost part of Workers' Compensation. In the last 3 years, I have paid over $50,600 in premiums and had less than $3,600 in claims. This year my rates will increase 30 percent.

There is a perception that small business owners are wealthy people. Well, most of us live on a modest income in relation to our heavy investment and debt load. Many employees of small businesses make more than the owners and do not have the liabilities. Mandated programs could be the straw that breaks the backs of these small businesses, and they will be forced to follow the Xeroxes of the world who have announced large layoffs simply to stay in business.

In summary, the proposed legislation on health care reform introduced into the Senate by your fellow Senators John Breaux and David Durenberger seem to offer a much more real world approach to health care reform.

The Managed Competition Act of 1993 is not perfect. I would encourage moving away from the concept of mandatory purchasing cooperatives, but overall I view this legislation as the best alternative to all other plans so far.

Thank you for your time. And remember, small business and the food service industry is the largest employer in America and structuring a plan that is negative to our industry would have many unfavorable results to your constituents.

The CHAIRMAN. Keith, thank you very much. That is a very compelling statement. Vernon?

STATEMENT OF VERNON NELSON, PRESIDENT OF THE NELSON GROUP, INCORPORATED, LITTLE ROCK, AR

Mr. NELSON. Thank you, Senator Bumpers, for the opportunity to present this statement. I am pleased that you are interested in hearing the concerns of the small business owners of the State. President Clinton's health care reform plan is a very commendable and gallant effort. We all agree to tackle an issue that has needed attention for a long, long time. I am in full support of ensuring that all citizens of this country have access to high quality health care while controlling those costs.

My company, the Nelson Group, Inc., provides environmental professional technical services, and we work as partners with our clients to preserve the environment and protect human health. Our business mission is to develop innovative, cost-effective solutions to

existing problems, and proactive solutions to anticipated problems. Prevention is the best medicine. Therefore education and behavior modification must be included in the health care reform plan which, when implemented effectively, will help to manage some of those costs.

With the cost of health care spiralling higher and higher, insurance coverage and affordable services are already beyond the reach of many small businesses, such as the Nelson Group. As a small business owner, I am fully cognizant of the fact that quality health care will cost and that the money and the funding for that has to come from somewhere. One of my primary concerns, of course, is the effect of this new plan on the employees of my company, and the many other small businesses around this country.

This plan must take into consideration the plight of small businesses and have the vision to prevent those adverse effects. Small business is and will be the back bone of this country and we need to ensure their longevity by developing health care plans with their best interests in mind.

I also would like to say that after 5 years in business, after leaving the corporate structure, I initially had to join a small business association in order to have health care coverage for my family at a very expensive tap. After a number of years when I could not provide this to all my employees, I felt the need in building a relationship and in supporting my staff to make available to them some form of insurance coverage. Therefore we sought another carrier. At this point, the insurance premiums for health care and disability alone is costing us approximately 12 percent of our gross salary dollars.

The CHAIRMAN. Are you saying 12 percent of the payroll dollars?

Mr. NELSON. Payroll dollars. This is, of course, presented to our employees as an option, and if they have other sources of coverage, we are allowing them to exercise their option on which coverage they would like to have. Again, there are many, many small businesses around this country that have staffs and employees who have no coverage at all. I certainly understand the plight of those citizens in this country who are either unemployed or have no coverage or no avenues for this coverage at all, and those are some of the real problems that we are facing with this health care reform program.

The cost is already prohibitive, and we all know that. I compare this dilemma with the health care issues with a very giant jigsaw puzzle, and when you first start to tackle this problem, it is seemingly unsurmountable unless you have the goal, first of all, the attitude that I am going to put this puzzle together one way or the other and I am going to finish it. As you begin to work on that puzzle, as the pieces begin to fall together, you begin to see patterns and colors and things of that nature that, as you get further and further along, your pace begins to pick up a little bit. I think the job of political leaders, community leaders, health care providers as well as business owners all have a part in putting that puzzle together, and the willingness to tackle this problem is the first step of that process and it is not going to stop at this point. I am absolutely certain of that, with the Clintons' efforts on this program.

Disparity between the haves and the have-nots, as you may call it, has widened considerably. I will share with you an experience of that. I grew up in the Arkansas Delta. As a matter of fact, my family physician was a physician at Holly Grove in the mid 1960s. I recall a time when I was a child, I had abdominal problems and pains and I was afraid to tell my mother that I was even in pain. So I let that problem drag on for a number of days, and when she found out that I was not moving around like I normally should have, the bratty kid that had too much energy, she took me to the doctor, and the doctor diagnosed that I had appendicitis and it was near bursting and they had to rush me off to the hospital. But one thing I remember about that family physician at that time was that money was not the issue. If a citizen in that community needed health care, that citizen got health care, regardless.

Now, of course, in this day and time, the physicians and the hospitals are in business to make a profit and we cannot take that away from them. But again, the physicians and the hospitals and everyone has to be willing to tackle these issues and everybody deserves quality health care.

Service, delivery, access, cost, all of these issues are parts of the puzzle and we have to solve all of them.

We in environmental engineering, believe that a successful plan and project is achieved by design, not by chance. Therefore we all have our work cut out for us to make sure this plan is a successful plan by design. And the public health care clinics, of course, is the first step in getting that preventive mode of corrective action in place, because we have to educate the people and we also have to emphasize behavior modification to correct these problems.

The CHAIRMAN. Vernon, how many employees do you have?

Mr. NELSON. We have 10 employees.

The CHAIRMAN. Okay.

Mr. ABNEY. If I might add one other thing you should be aware of.

The CHAIRMAN. Yes?

Mr. ABNEY. We hear a lot about how interest rates are down and how attractive that is right now. The double edged sword of that is the small businessman, such as myself, finds it very difficult to get refinancing in the State of Arkansas because of the interest rate, the laws, and the cloud of potential mandated costs. I purchased my restaurants 3 years ago and borrowed money from a German bank because no one in Arkansas was interested in long-term fixed financing. I, like many other people, have refinanced my home—I just refinanced my business. And after talking with the largest financial institution in this state, the cloud out there of the business expenses next year, I had to refinance with a large insurance company outside the state once again, which I do not like to do. In-state customers are my business, I like to do business here, but we are handicapped because——

The CHAIRMAN. Amen. You borrowed from a German bank?

Mr. ABNEY. Yes, sir.

The CHAIRMAN. Did you try the Small Business Administration?

Mr. ABNEY. We have not been successful.

The CHAIRMAN. You have such a distrust in government, you would not dare, right?

Mr. ABNEY. No, sir, I would have had my wife make the application instead of myself.

The CHAIRMAN. Well, I will say this. I totally agree with Greg. I have never been particularly close to bankers until the last few years. They kept hammering on me and I got interested, and now I am their most ardent champions. I think we are wasting somewhere in the vicinity of 15 billion dollars a year, in this country on overregulation of financial institutions. That is all reaction to the so-called S&L debacle. It was bad enough even before that. But now the banks of this country are asked for an inordinate amount of information, which nobody ever looks at, and it costs them tremendous sums of money. Senator Chafee of Rhode Island and I have introduced a bill to try to help, but it is minuscule compared to what needs to be done.

Now, the President submitted that, this is not totally on the subject we are talking about here, but I have been on the Small Business Committee almost ever since I have been in the Senate and I have been the Chairman for the last 7 years. And I might say, Keith, that I, as a former small businessman with six employees, never really thought of small business people as being well to do. I have a very contrary view, because I have just had too many of them before my Committee to tell me what a tough time it is. My son is in the chocolate chip cookie business, he is the chocolate chip cookie tycoon, soon to be Back Yard Burger tycoon. I know how long it took him before he was in the black. It took a long time, and I know from my own experience, the small business person has a very tough, tough go.

Now the reason we are here today, representing the small business community, is because the impact on small business is the most difficult part of the whole bill to me. Based on what you said, and I know that is compounded thousands of times, I am going to have a very difficult time with that part of the President's proposal right now. There is not any question that it will put some people out of business, it will cause others to layoff employees.

Let me make one other observation. You saw yesterday where Xerox was going to layoff 10,000 people, you see every day where some big corporation is going to layoff 10,000 to 20,000 people over the next few years. They are doing that for a lot of reasons. But one reason is because the Government has put so many mandates on them. In order to stay competitive, they have found out that they can get by with fewer people, and they are not just laying people off willy nilly, they have found out they can actually operate with fewer people.

So, when you ought to be getting a competitive edge, we are not gaining very much. What we are doing is just putting more Federal mandates on them and they are having to layoff people to make up for it, so they are no better off and nobody else is any better off.

Anyway, let us get back to what we are here to talk about. I invited Mrs. Clinton over to lunch in the Small Business Committee room. And all the members came, we shut the door, no press, no nothing, and I just let the First Lady make her presentation and let each member of the Committee ask her questions. Of course she is always brilliant.

The first question was from a western Senator, who is also a very successful and wealthy businessman. And he said, "Mrs. Clinton, if you walk down the street, the first guy you come to is the baker and he is struggling to carry health insurance for his employees. And across the street is the insurance company, they are trying to carry a local agent, 10 employees, and he is struggling trying to maintain health insurance for his people. At the end of the street is the garage with five mechanics and three gofers. He has no insurance and has no interest in getting insurance for his employees."

Now, he said, "Are you going to make him, whether he wants to or not, carry insurance?" She said, "Yes." And she said, "The reason is because the baker and the insurance company are paying for his people now. If somebody has something wrong with his sacroiliac because he is under a car and rolls over a screwdriver, he is going to go to the hospital and he is not going to be turned away simply because he does not have insurance. That is a trauma and in all probability the hospital is going to go ahead and treat him, in all probability they are not going to get a dime in compensation. So you know what happens? They have to raise their room rate, they have to raise the rate for the operating room, for the intensive care unit and all those other things. You know what happens then? The premium for the bakery and the insurance guy goes up, because they are effectively paying for the care of the garage guy who is not carrying an insurance policy."

Do you agree with that? Does that make sense to you?

Mr. ABNEY. I am sure the hospital has to recover their cost from somewhere.

The CHAIRMAN. Well, all you have to do is talk to any hospital administrator about how much free care they are giving. Just talk to people at Arkansas Children's Hospital. I am going over to that hospital tomorrow afternoon as a matter of fact because I like to go over there periodically and get an update on what they are doing. And I can tell you one of the things that they are going to tell me is how much free care they gave last year. But as I say, it really is not free, they have to raise their rate to take care of that roughly 40-50 percent or whatever it is of the free care they are giving. So, you and I are paying for it. Vernon?

Mr. NELSON. I wanted to mention that in the context of the Workers' Compensation issue. For example, we go and look at a company, look at an Arkla system that has had problems with high cost, unmanageable workers' health cost and liability issues and workers' issues that are almost unimaginable to a small industrial operation, and when we go in to assess and evaluate the real sources of the problem, we find that there are reasons that the insurance companies are having to drive the premiums up to offset the cost for these claims. We are finding that the resulting issues of the injuries, the exposures, the health problems that are coming out of some of these industrial operations is a result of the management of these firms not managing those risks properly.

We do an analysis and we basically develop programs for the improvement of the health and safety management risks in the operations, and oftentimes we find there is always a down scale possible

with these operations where we can eliminate these costs and unnecessary increases and unnecessary goals.

The CHAIRMAN. Now, let me tell you the magnitude of the small business problem in this bill. If anything sinks the President's proposal, it will be the antipathy, the antagonism and the outright hostility of the small business community in this country to this bill. That is how strongly I feel about it. I know that is true. I know what my mail is. The providers, the hospitals and doctors are all considerably upset about it. But I can tell you, half of all the workers in this country are employed by small business. In 1990, Arkansas had a total of 66,800 businesses total. 66,800. Of which 62,700 were small business. Now, that is what makes America go in this country—small business.

So, you can see that big business really does not have the political clout in this bill that small business does, because there is 20 times more small businesses than there are big business. And if enough of them say you are going to put me out of business, this bill is in difficulty.

Mr. ABNEY. I think you have broad brush statements of "X" number of employees or "X" number of hours a week. Vernon's business might only have 10 employees, but it might be an extremely profitable business that he is in. Where another person might have 10 employees and it is a very narrow margin in their business.

By just saying it is going to cover 50 employees or 75 or whatever it might be or a number of hours, each business has a different profit structure. A person with 10 employees in one instance might have a very profitable business, whereas another one with 10 employees might be a mechanic or a baker who is working on a very, very thin margin, and the impact is significantly different. But because they fall under a set number of employees, or a set number of hours—I challenge you to have dinner with your son and let him put pen to paper to determine his costs, because you have got to have "X" number of people——

The CHAIRMAN. He used to come by for dinner, but he doesn't anymore.

Mr. ABNEY. And it is a concern. When the hospital incurs the cost, I am sure that my family and other people with insurance are helping to absorb that cost and we all feel that there has to be reform and we are willing to do our share. Obviously the concern arises as each person takes a little bit more of the pie, i.e. the syrup tax, i.e. as you related to the Social Security taxes that keep going up, the pie is——

The CHAIRMAN. Did you see 60 Minutes Sunday night?

Mr. ABNEY. Yes, sir.

The CHAIRMAN. Did you see it, Greg?

Mr. BROWN. Yes, sir.

The CHAIRMAN. That was a pretty powerful statement on Social Security, was it not?

Mr. BROWN. [Indicated yes.]

The CHAIRMAN. That is a separate issue and we could talk about that all day. But I use an illustration—among the other responsibilities I have, I am also Chairman of the Agricultural Subcommittee on Appropriations. We appropriate 75 billion dollars a year.

And that includes the Food and Drug Administration as well as food stamps and a lot of other things, but so little of it goes for the farmer you would not believe it. But ever since I have been on the Agricultural Appropriations Subcommittee, we have done our very best to create a crop insurance bill that would work. We have long since concluded that the only crop insurance proposal that will work is one that requires every farmer to carry it.

Now, you know what that does, Farm Bureau does not like the idea of mandatory crop insurance either. But I can tell you it will never work until it is mandatory. Despite our best efforts we have only been able to get about 50 percent of the farmers in this country to insure.

So what happens? You have this gigantic massive flood in the Midwest, and what does the Government do? We send massive amounts of aid out there. I would not have it any other way. That is the great thing about America, we are a compassionate nation. People hate government, but when they get in trouble, they sure do not mind turning to the Government. We all understand that. And we have sent billions of dollars to the Midwest to try to make those farmers whole and keep their head, I hate to say this, above water. In this case that's really what it was.

But you tell me what incentive now is there for anybody in the Midwest to carry crop insurance when what we are doing for them and under the flood formula of the money we sent to the Midwest, the guy who went down and was very circumspect and efficient and bought crop insurance gets five percent more than the guy who did not buy any crop insurance. You are not ever going to get farmers to buy crop insurance when they know the Government is going to come to their rescue anyway at the time of a disaster. And I and all of the Senators, if our states are affected, we are first up on the floor talking about the terrible plight of our poor people in one place or another, whether it is a flood or fire or whatever. And so it is.

I used that illustration when Mrs. Clinton appeared before this Committee, and she said she thought that was precisely on target of what she was talking about. But here is a short summary of what we are talking about on small business recovery—every small business would have to pay a portion of the employee's health insurance. Companies with 75 employees or less are considered small.

Do you know that?

Mr. ABNEY. [Indicated yes.]

The CHAIRMAN. You have 105 employees, I made a quick calculation this morning?

Mr. ABNEY. 105.

The CHAIRMAN. Now, the staff tells me you are not going to be able to separate those two McDonald's, you are going to be considered as one entity, so you are not going to be counted as small under this.

So, if you have over 75 employees or less, you will pay a sliding scale of your payroll, from 3½ percent to 7.9 percent, calculated thusly. If the average wage in your business, and it certainly would be in yours, of all your 105 employees is $12,000 or less, you would only pay 3½ percent of your payroll. The Government will subsidize the Arkansas alliance for the difference between that and 7.9

percent. As your payroll goes up, there is a sliding scale up to 7.9 percent. Number one, one of the things that troubles me about that is that is an incentive for me as a small businessman to keep my wages down.

Mr. ABNEY. Right.

The CHAIRMAN. The lower the wages the more subsidy you are going to get.

Mr. ABNEY. Right.

The CHAIRMAN. Number two, if you have more than 75 employees, and I do not care if the average wage is $10,000, you have to pay 7.9 percent. So, there is another big incentive to employ fewer than 75 people.

Mr. ABNEY. That is right. And if I have multiple locations like you just said, that means I have got to have 75 total. I am a sole proprietor.

The CHAIRMAN. Are you? You do not have an incorporated company?

Mr. ABNEY. I am a sole proprietor.

The CHAIRMAN. If we get mandatory proposals, Keith, I will send them to you.

Mr. ABNEY. But 30-something employees right now in my mind I have to eliminate.

The CHAIRMAN. Here is a schedule. If your employees' average wage, no matter how many employees you have under 75, is $24,000 or more, you are up to the 7.9 percent limit.

Mr. ABNEY. I am over the 75 and under the $12,000.

The CHAIRMAN. So you are not going to get any subsidy.

Mr. ABNEY. I am not going to get anything, right.

The CHAIRMAN. Now, Vernon, you might? Tom, how many employees do you have?

Mr. MURRY. Eight. From what you just told me, I am looking forward to it passing. Because I pay 100 percent of a very high premium for everybody I employ.

The CHAIRMAN. Do you know that this will save you money?

Mr. MURRY. I hoped.

The CHAIRMAN. It will.

Mr. MURRY. That was my understanding, but you just made it very clear.

The CHAIRMAN. Well, that is something I figured out yesterday. For example, an average employer will pay 80 percent and the employee will be called on to pay 20 percent. Now, if you have been paying 100 percent of your cost, you are going to save that 20 percent.

Mr. MURRY. Looking forward to it. My only point was I feel like we have got to have cost control, and I am all for the reform. My experience about the quality of care is my only concern. And that is what a lot of people whom I talked to, since I realized I was going to be testifying, were all concerned about with the quality of care, are we going to end up having to wait in line, are we ever going to be able to get an appointment.

The CHAIRMAN. One of the very controversial parts of the Clinton proposal is that if you have less than 5,000 employees, you cannot self-insure. Now, in small business parliaments, sometimes you can have 500 or less and still be considered small business in

this country, depending on what it is, what your gross income is and so on.

But I have a good friend up in Russellville who has 400 employees and he has been self-insuring for 3 or 4 years and very successfully. He is going to take strong exception to being told that he may no longer self-insure. He may not want to. It may be that under this plan the thing that made him go to self insurance is no longer an impediment to him and he will not want to self-insure.

I have another friend in northwest Arkansas with 11 big integrated poultry companies in this country who told me that he is self-insuring. He has 3900 employees, so under the Clinton proposal he would not be allowed to self-insure. But he tells me that under the proposal it will cost him two and a quarter million dollars more than he is spending right now for health insurance, and that is considerably more than his profit/loss ratio last year. Now, 3900 employees is not small business by any stretch of the imagination, so when you start talking about, you know, really doing grave damage to a man in that category, you have got a big problem, too.

I am going to submit this "Impact of Clinton's Healthcare Plan on Small Business," just the substance of this memo that my staff prepared for me about precisely how this program works for small business people.

[Information referred to follows:]

IMPACT OF PRESIDENT CLINTON'S HEALTH CARE PLAN ON SMALL BUSINESS, NATION'S BUSINESS, U.S. CHAMBER OF COMMERCE, NOVEMBER 1993

1. Every small business would have to pay a portion of its employees' health insurance. Companies with 75 or fewer workers and average annual pay no higher than $24,000 would have their costs capped as a percentage of payroll, beginning at 3.5 percent and rising to 7.9 percent.
2. Based on national averages, employers would pay $1,546 for each single worker without children and $2,480 for each worker with children—whether married or single. May employers qualifying for premium caps would pay less.
3. Employees would select a health plan from the range of plans offered by the regional purchasing alliance.
4. Employers with fewer than 5,000 workers would no longer be allowed to self-insure.
5. Regional purchasing alliances would have no role for insurance agents and brokers in selling standard health plans, but agents could sell supplemental policies.
6. The self-employed and independent contractors would pay the entire cost of their insurance, but, like any other business, they would qualify for premium caps. The total cost would be 100 percent deductible as a business expense.
7. Employee-leasing and temporary-worker companies would pay the 80 percent employer share of health insurance for all the workers they provide to other companies; leased and temporary employees would pay the balance.
8. Part-time workers up to age 23 would be covered by their parents' health insurance and would not be an employer's responsibility.
9. Employers would pay for all other part-time workers putting in 10 or more hours a week, prorated on the basis of 30 hours per week equaling full-time employment. Seasonal workers would be prorated on the basis of weeks worked.
10. Employees could no longer use flex-plan pre-tax dollars to pay their share of health premiums or out-of-pocket expenses not covered by their health plan.

The CHAIRMAN. My son, I hate to keep talking about him, but we had a long conversation last night, and he said, "You know our chocolate chip cookie business in the last 4 months of the year does more business than the first 8 months. We have a lot of temporary employees. How does that affect us?" I did not know the answer. You have to pay for them.

Incidentally, there is another big industry growing up in this country in the last few years called temp organizations. Keith may send you five employees for 5 days or 10 days, or whatever you want them for. Now they can continue to do that, but they are going to have to pay the insurance, Workers' Compensation and everything else on those people.

Mr. ABNEY. Do you know if the number of 75 refers to at any point in time during the year or——

The CHAIRMAN. It is an average I think, is it not, Maryann?

Ms. CHAFFEE. [Indicated yes.]

Mr. ABNEY. So, if you happen to be in an industry with high turnover and you might actually employ 300 employees throughout the year instead of the hundred——

The CHAIRMAN. No, I think it is probably calculated on a monthly basis, you take the average number of employees you have each month, divide that by 12 at the end of the year. If it is less than 75, you are small business.

Mr. BROWN. Senator, if I may, I think talking about 75 and the average and how it is counted, that is one of the problems. I know that I stand out in particular, because of my banking background, but I think that is one of the problems that all of us as small businessmen have with regulation per se. You yourself commented earlier that it depends on what your volume is and what number of employees you have, it depends on which agency as to whether you are a small business or not. Apparently under the proposed legislation, an average of 75 employees is the trigger. Well, I dare say that nobody up here currently has to calculate the average number of employees they have during the year. That is one added burden that is not——

The CHAIRMAN. I agree.

Mr. BROWN.—that is not that substantial taken by itself, but when you take it with every other little added burden that comes out of Washington, it gets to be a real mountain of regulation.

The CHAIRMAN. Incidentally, if you are 23 years of age or younger you would not be covered as an employee, you are considered to be a part of the parents' program. I am not sure how that works. That came to me as something new this afternoon.

Well, as I say, I want to keep us on schedule. I cannot count how many hours I spent on this issue, and yesterday I really crammed in preparation for this hearing, and everything raises another question. It is the most complex problem by far. And I hate to tell you this, Keith, but something is going to happen. I do not know whether it is going to be good or bad, but I can tell you we are going to come up with some kind of a health care plan.

Mr. ABNEY. Oh, I am sure you will, and I think there are some proposals out there that I am not opposed to. One last question I would add, in this state and your son will find this, because we have a high number of single parents in this state, and especially in our industry, does that then mean that every employee would be family coverage versus single coverage? See, a great number of our employees do have children, and because of some of the incentives—and the way the incentives are set up, it is not to their advantage to be married.

The CHAIRMAN. I can tell you that you pay $1,546 for a single worker and $2,480 for a worker single or married with children. Now, you may start hiring nobody but single people.

Mr. ABNEY. Then I am sure I would be in discrimination of AEA.

The CHAIRMAN. I am just saying everything here has an incentive to do something else. So that is, as I said, what makes it complex. But I cannot tell you how much I appreciate your coming here. You know, I am just one player in this. Senator Pryor is on the Finance Committee. That is one of the two committees in the Senate that has primary jurisdiction over this. The Senate, to some extent, is interested in what I think about the small business aspects of health care or anything else. I want to be sure that I am up to speed on this issue before we start debating it so that when I do speak on behalf of small business, I have the benefit of things that I have heard here this morning, at other hearings that I intend to hold, both here and in Washington. You all are a tremendous help to me, and I admire all small business people. And believe you me, as a former small business person, who often wrote checks on Friday afternoon without the money being there to cover them, I know what it is like and you do, too. Thank you all.

We are going to take a 5-minute recess at this point.

[Whereupon, a brief break was taken.]

The CHAIRMAN. Our third panel this morning is Norine Yukon, executive director, Prudential Health Care Plans of Arkansas. Bob Cabe, senior vice president External Services, Arkansas Blue Cross Blue Shield. Stephen Madigan, vice president, Seabury and Smith, Little Rock, AR. This is the panel representing the insurance industry.

I'd like to point out that I have to give a speech at the Baptist Medical Center at lunch to the Central Arkansas Life Underwriters. Norine, you are number one on my list, so please proceed.

STATEMENT OF NORINE YUKON, EXECUTIVE DIRECTOR, PRUDENTIAL HEALTH CARE PLANS OF ARKANSAS

Ms. YUKON. Senator Bumpers and ladies and gentlemen, I am Norine Yukon, executive director of Prudential Health Care Plans of Arkansas, a subsidiary of the Prudential Insurance Company of America. I am here today on behalf of Prudential, which represents nearly 4 million managed health care members nationwide. In Arkansas, we currently insure 30,000 citizens in our managed health care plans. We have 400 physician partners and nine hospital partners and we represent well over 200 different employers.

Thank you for inviting me to speak with you today. This is certainly an exciting time in Arkansas to be involved in health care.

Our State and our country are at last reaching a consensus that something must be done about health care.

I congratulate those people who have spent countless hours learning the intricacies of our health care system. I commiserate with those who are just beginning the process. It is enormously complicated, once you get behind the rhetoric.

There are many different plans now competing for attention. And competition has always been the essence of life in the United

States. But for the moment, what is most striking is that so many agree on so much.

We agree that insurance should be made portable to eliminate job-lock, that there should be no restrictions on preexisting conditions so that people can keep their health coverage no matter what their health status is. We agree that there should be group purchasing pools so that small employers can offer health benefits like large companies do, and that self-employed workers should be allowed to deduct the full cost of health benefits, just as corporations do. We agree we need better research on medical outcome so we can learn what really works in the practice of medicine, and then translate that into clinical practice. And we agree we need to reduce paperwork. Finally, we all agree on the need for tort reform.

Now, we can argue all day long about who has the better plan, but can we agree that we do not want government stepping in and mucking up the works? The Government should make changes, but the last thing we want is for one-seventh of the Nation's economy to be turned over to the Government.

As Robert Samuelson wrote in the Washington Post a few months ago, "Just because the present system is flawed does not mean we cannot make it worse."

The Clinton plan does represent real change. It includes coverage for all Americans and new ways to measure quality. It rewards consumers for making wise health choices. Each of these items could place more power in the hands of the consumer which would revolutionize the health care economy.

Unfortunately, when it came time to decide how to police this new system, the administration lost its way. It opted not for change, not for the cleansing discipline of the market, for the tired belief that government knows best.

The President says there are not going to be price controls, which everyone knows have never worked. But tell me, what are premium caps if not price controls? Premium caps based on the CPI is how the President intends to control prices.

And what are global budgets except a top-down approach to limiting spending on health care? This approach has nothing to do with consumers making choices about which health care plan is more efficient.

Global budgets mean government deciding, in infinitesimal detail the limits to consumer spending.

When you look at the huge, heavily-regulatory government-controlled health alliances the administration's plan could create, when you look at the power in the hands of the National Health Board, you realize the plan will make the Government bigger and more intrusive.

Now, do not get me wrong. Alliances that were designed by Paul Elwood and the Jackson Hole Group, these are an excellent idea and they are desperately needed. But there is no need to fold 99 percent of the employers into them to give small businesses a way to reduce their health costs. It is overkill and it could kill healthy competition.

Global budgets, price controls, heavy regulation at the state and federal level, these are the tools of a nervous central bureaucracy, not a free-wheeling market-based economy.

Market-based health care reform that President Clinton envisions, that most of you would support, is already occurring in health markets all around the country, thanks to managed care.

Little Rock employers are demanding new ways to get a handle on runaway costs and to improve quality in the health care delivery system. Companies like mine are developing innovative ways to reduce costs and increase quality. Let me give you just one example.

In the summer of 1993, Prudential began a program called Starting Right, and this is designed to identify pregnant members with the risk of premature birth. Since the inception of this program, we at the Prudential Little Rock plan have identified four women who were at risk. These women were treated at home with medications and monitoring devices to extend gestation. Three of these women delivered full term babies, and one woman delivered her baby only 2 weeks early. All four babies were delivered with no complications and all were in good health. Had these women delivered when their preterm labor began, all four babies would have been admitted to the neonatal intensive care unit and had probable serious health problems. In addition to impacting the quality of health care, our early intervention saved approximately $100,000, and probably a lot more had these babies had very, very serious complications.

Innovations like these not only save money but they improve people's lives. We must preserve the market forces which generate these kinds of changes.

I congratulate the President on having the best intentions on market reform, but I urge him to let the market do the job it can. Managed competition will not work without the freedom of the marketplace, to innovate, to market and to price. But given that freedom, managed competition can bring real health care reform.

I am encouraged that there is support on both sides and in both houses for the change that managed competition represents. Thank you.

[The prepared statement of Ms. Yukon follows:]

PREPARED STATEMENT OF NORINE YUKON, EXECUTIVE DIRECTOR OF THE PRUDENTIAL HEALTH CARE PLANS OF ARKANSAS

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There are many different plans now competing for attention. Competition has always been the essence of life in the United States. But for the moment, what's most striking is that so many agree on so much: We agree that insurance should be

made portable to eliminate "job-lock", that there should be no restrictions on pre-existing conditions so that people can keep their health coverage no matter what their health status is, that there should be group purchasing pools so that small employers can offer health benefits like large companies do, that self-employed workers should be allowed to deduct the full cost of health benefits, just as corporations do, we agree we need better research on medical outcomes so we can learn what really works in the practice of medicine, then translate that into clinical practice, and that we need to reduce the paperwork. And finally, we agree on the need for tort reform.

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I am encouraged that there is support on both sides and in both Houses for the change that managed competition represents.

Thank you.

The CHAIRMAN. Thank you, Norine. That is a very interesting statement. Bob?

STATEMENT OF ROBERT CABE, SENIOR VICE PRESIDENT, EXTERNAL SERVICES, ARKANSAS BLUE CROSS/BLUE SHIELD

Mr. CABE. Senator, I am here on behalf of Arkansas Blue Cross and Blue Shield, which is a nonprofit mutual insurance company based here in Arkansas. Together with its subsidiaries, Arkansas Blue Cross and Blue Shield either insures or administers the health benefits for over 500,000 Arkansans. On behalf of those Arkansans, we thank you for this opportunity to present our views on some of the issues in the health care reform debate.

Arkansas Blue Cross and Blue Shield supports unquestionably fundamental reform of health care in the United States. In fact, at a previous hearing you held in Little Rock in January 1992, we issued our initial statement of position with respect to health care reform. Our position then and now is largely consistent with the program that President Clinton has proposed in the Health Security Act. The fundamental principles, fundamental philosophies we think are accurate and are appropriate.

We have laid out in our prepared statement some of the specifics of what we support, and rather than reiterate all of that, I would like to focus somewhat upon issues where we think that flexibility that has been invited by the President should be taken advantage of and some changes in the program suggested by the President ought to be considered.

We think it is terribly important that the list of reforms, generally speaking, be fully implemented and that we do not pick and choose certain pieces of it to the exclusion of others. Otherwise we do not think we will be able to achieve the kind of cost control and improvements in access and quality that is the goal of all of us in the health care reform situation.

In Arkansas, for example, we have passed the NAIC small group rating and renewal act which places some limitations on rating for small employers and restrictions on nonrenewal. However, before we can expect some reforms like guaranteed issue, guaranteed renewal, and community rating to properly work, we are going to have to bring virtually everyone into the system to participate in and contribute to the system. Otherwise we are going to be subject to the same kind of cost shifting and refusal to cover high risks that aggravates our problem today and exacerbates the number of uninsured people that we have in this country.

Turning specifically to the structure of the regional alliances, we think that alliances can play a critical part and are an appropriate part of the health care reform——

The CHAIRMAN. Bob, I am going to ask you a question, because I might forget it. Right now I am reluctant to interrupt you. Let us take Blue Cross and Blue Shield, which is such an integral part of Arkansas and has been for so long. Let us assume that we have an alliance, just for hypothetical purposes, that covers all of Arkansas, and they put this basic package out for bids and ask you, Pruden-

tial, Metropolitan and everybody else to bid on it. Now, you are Blue Cross and Blue Shield of Arkansas.

Mr. CABE. Yes.

The CHAIRMAN. But let us assume that Prudential has the lower bid. Are you out of business?

Mr. CABE. Well, it would depend. If you are speaking of bids in terms of participating as an accountable health plan and being able to sell to members of the alliance, no, I do not think under the structure of the Clinton proposal that we would be out of business, because there was a lower bid, because there will be some price differential between accountable health plans and the products they offer. As I understand it, consumers will be afforded additional information regarding not only costs, but also——

The CHAIRMAN. Well, they can give members of the Alliance as many options as they want to, can they not?

Mr. CABE. Right, right.

The CHAIRMAN. Depending on what they are willing to pay for. But I am talking about the basic package, you would go out of business on the basic package, would you not?

Mr. CABE. I do not understand that the alliance would exclude everybody else.

The CHAIRMAN. Let me ask you a question, because I think this panel probably knows a lot more about this than I do. But as I understand it, the alliance will ask Prudential, Blue Cross and Blue Shield and everybody else, to say here is a basic package, you must cover these benefits, and what do you bid? If Prudential is the low bidder, everybody else so far as that package is out of business, are they not?

Mr. CABE. [Indicated no.]

The CHAIRMAN. No? Okay. Explain it to me.

Ms. YUKON. Again, if we are talking about competition, we are talking about different delivery systems. So one delivery system may revolve around a certain hospital and a certain panel of providers.

The CHAIRMAN. So, there are going to be a lot of people involved in this bidding?

Ms. YUKON. Right.

The CHAIRMAN. And there will be a lot of successful bidders?

Ms. YUKON. Right.

Mr. CABE. Sure.

Ms. YUKON. The benefit package might be the same, but the delivery systems themselves, in terms of the composition of the hospitals and physicians are different, so people have a choice. People also have a choice in terms of the kind of service that they are given.

The CHAIRMAN. Okay.

Ms. YUKON. In terms of how claims are paid, in terms of how the telephones are answered, in terms of how the case management that might be delivered by a health plan. There are a lot of services that delivery systems are going to offer.

The CHAIRMAN. Okay. I did not understand it. Bob, I am sorry I interrupted you. Go ahead with where you were.

Mr. CABE. Just to add to that, I think that the plan contemplates that each one of those plans that is qualified to make its program

available to the public will have to publish information regarding patient outcomes of the people who participate in that plan, and also regarding patient satisfaction over the way they receive their services.

The CHAIRMAN. I might say that score card business is another thing that concerns me. You know, Denton Cooley probably had the lowest score card of anybody in the country because he gets the most difficult cases.

Ms. YUKON. Right.

Mr. CABE. In terms of patient outcome, yes, that is a difficult and complex issue, but in terms of getting some general information to consumers that they do not now receive, we think that that is certainly worth pursuing, and part of the whole idea of an educated consumer, if they are to make a reasonable market choice.

With respect to the alliances, we think that alliances can provide an essential service as part of the structure of a new system. We think that if they are appropriately structured and commissioned, that mandatory alliances for small employers can work. We believe that alliances should have to operate under a uniform set of guidelines that is established at the Federal level and enforced at the State level.

The idea here is that part of our problem today is a patchwork of 50 different sets of regulations for the insurance industry, depending on what state you are operating in. And we think we have to get away from that if we are going to effectively reform the system.

We think with respect to alliances, that the nonprofit corporation alternative is the best structure for the alliances of those that have been suggested in the President's plan.

We have another set of concerns, which has to do with an extended multiyear phase-in of the plan. We think the phase-in needs to be compressed as much as possible, because there are problems with an extended phase-in, such as duplication of costs with a new system alongside an old system.

We agree with what has been said before, that premium limits or price freezes put in before we have a full range of cost containment features can really drain off some of the capital that is out there available to fund the infrastructure needed in the new system. We are going to have to spend some money establishing systems, establishing networks, establishing communications capabilities and other capital needs for a reformed system to work, especially in a state like Arkansas. We are going to have to equip those rural physicians with capabilities for communication and for access to services and expert opinions that are going to cost some money.

I think the bottom line for us is do we want government to run the system or do we want to preserve the opportunity for the private sector to bring the kind of innovation, administrate efficiency, risk assumption, and most essentially the capitalization that is going to be necessary for the reformed system to work. We think that only through maintenance of the private system as a major player in this can we accomplish that goal. Thank you again.

[The prepared statement of Mr. Cabe follows:]

PREPARED STATEMENT OF ROBERT CABE, SENIOR VICE PRESIDENT, EXTERNAL SERVICES, ARKANSAS BLUE CROSS BLUE SHIELD

INTRODUCTION

Arkansas Blue Cross and Blue Shield, a Mutual Insurance Company ("ABCBS") appreciates this opportunity to present its views on some of the issues currently being discussed in the context of the debate over health care reform in the United States. We commend Senator Bumpers for holding this hearing to obtain the views of the citizens of Arkansas on these important subjects. Sessions such as these are, in fact, imperative in view of the complexity of accomplishing fundamental reform of an industry accounting for approximately one-seventh of the national economy.

ABCBS is a non-profit, mutual insurance company licensed and operating in the State of Arkansas. It is an independent licensee of the Blue Cross and Blue Shield Association, and it is the largest health insurer in the State of Arkansas. Together with its subsidiaries, ABCBS insures or administers health care benefits for more than 500,000 Arkansans.

ABCBS SUPPORTS HEALTH CARE REFORM

In January 1992, ABCBS issued a public statement of its support for fundamental reform of health care in the United States. While this statement of support for specific reform measures was issued prior to the introduction of some of the major reform proposals now pending before Congress, the ABCBS position was and is largely consistent with the principles underlying President Clinton's proposed Health Security Act.

Specifically, ABCBS supports the following:

- Fundamental reform of the health care system in the United States; the current system is broken and must be re-engineered for the twenty-first century.
- Universal coverage, and universal participation in the funding of a national health care program.
- Global budgets and reasonable expenditure limitations.
- Establishment of a national health board with the roles and responsibilities outlined in the Health Security Act.
- Regional health alliances structured to operate as purchasing and certifying agents on behalf of individuals and small businesses.
- Fully integrated health plans operating under the purview of a regional alliance as a solution that is both workable and appropriate in balancing the factors of access, quality, and cost.
- Properly crafted insurance industry reform as early as practical. These reforms, applicable to insurers, self-insured employers and other health plans, should include:
  - Acceptance of all applicants, regardless of age or health status.
  - The offering of standardized, uniform benefit packages which can be easily compared.
  - The publication of information about consumer satisfaction and the health care outcomes of the patients of each plan's providers.
  - The utilization of community rating.
  - Continuation of coverage for people who change jobs, lose their jobs, or become sick or disabled.

It is, however, critical that these reforms be completely implemented, and that we are careful not to pick and choose some to the exclusion of others. In Arkansas, we have taken substantial steps, through the passage of the NAIC Small Group Rating And Renewal Act, which prescribes limited rating bands and restrictions on non-renewal for groups up to 25 employees. It is essential that there be universal coverage before we can expect reforms such as guaranteed issue, guaranteed renewal, and community rating to work properly. Without universal coverage, the marketplace will still be subject to the "dumping" of higher risk groups and individuals and exacerbation of the already critical level of uninsured individuals and families.

CONCERNS—REGIONAL ALLIANCES

Regional alliances are a key structure in several of the reform proposals now pending before Congress, although they vary considerably in organization and responsibilities. Assuming that health care reform is eventually organized around the concept of managed competition, regional alliances will play a critical role in determining the success or failure of that reform.

President Clinton, in particular, has often reiterated the theme of flexibility and willingness to refine his proposal in the interest of efficiency and effectiveness. Accordingly, we would offer the following observations about the proper structuring of regional alliances.

- Appropriately structured and commissioned mandatory health alliances are a vital component of needed top-down reform.
- Health alliances should be subject to a strict set of uniform guidelines prescribed at the Federal level.
- The general approach to the regional alliance concept could be analogous to the Securities and Exchange Commission or the Federal Reserve Board: They should set the ground rules and monitor the results, but avoid micro-management of the process of financing, delivery, and administration of health care.
- Of the options mentioned in the Health Security Act for the structure of regional alliances (non-profit corporation, independent State agency, or agency of the State executive branch), the non-profit corporation alternative is the most appropriate.
- There appears to be a consensus that reform could be substantially impeded if regional alliances grow into unwieldy, massive bureaucracies. Accordingly, all transaction-oriented administrative services, data processing, and reporting activities falling under the purview of regional alliances should be secured on a competitive bid basis from private sector vendors, similar to the current situation under Medicare, and, to a large extent, Medicaid.
- Along the same lines, the regional alliances should have at least the following options regarding their responsibilities for financial/actuarial matters and clinical quality assessment:
  - Option 1—Secure the services from an existing State agency (e.g., the insurance department or health department).
  - Option 2—Secure the services via competitive bids from qualified private sector entities.

OTHER CONCERNS

There are other problematic areas which warrant close attention if a truly viable reform initiative is to be forged.

- An extended, multi-year phase-in of health reform may result in major dislocations in the following dimensions:
  - Duplication of costs associated with the installation of a new health care system alongside the phase-out of the old one.
  - The imposition of premium limits or price freezes on large employers, multiple employer trusts, and insurers before other reform-based cost containment features are in place.
  - The increasing potential of Medicare and Medicaid cost-shifting, based on proposed aggressive reductions in Federal expenditures for these programs.
- The comprehensive managed competition model being proposed does not exist in an operational mode. The current reform proposals tend to build from an urban orientation where relatively mature managed care plans are currently in place. Arkansas and other rural States have special circumstances in terms of primary care access and lack of managed care presence that do not fit this urban model as a starting point in the reform process.
- Reform should be structured so that the private sector is given a reasonable opportunity to accomplish industry restructuring through innovation, administrative efficiency, risk assumption, and the required capitalization of conversion to a reformed system. If reform is not carefully designed in terms of a quick phase-in and the minimization of bureaucracy, it may drive the health care system toward a totally government-run system.

ABCBS AND THE NATIONAL INSTITUTE FOR HEALTH CARE MANAGEMENT

A major problem in reform of the health care system is the continuing lack of primary research and empirical data to support critical health policy decisions. ABCBS is pleased to be a founding member of the National Institute for Health Care Management. The NIHCM has already confirmed that many top congressional and other policymakers perceive significant gaps in the knowledge base needed to evaluate the effectiveness of the various proposals that have been and will be presented.

Accordingly, the goal of the NIHCM is to improve the delivery of health care services to all citizens by funding research designed to provide reliable and accurate information upon which a stable and effective health care system can be built.

The CHAIRMAN. Thank you, Bob. Steve?

STATEMENT OF STEPHEN MADIGAN, VICE PRESIDENT, SEABURY AND SMITH, LITTLE ROCK, AR

Mr. MADIGAN. I am pleased to address this Committee today as a representative of the insurance industry discussion panel. I would like to begin with an explanation of my perspective as a benefit consultant. As an officer within an insurance program management company, I have represented my clients in their jobs as benefit administrators in purchasing and acquiring health insurance programs for their employees. In that capacity I have watched the insurance industry evolve into a series of cost containment mechanisms and marketing schemes in an attempt to slow the rate of growth.

Today my comments and observations will focus on concerns about health care reform. Various legislative proposals pending before Congress will change time and time again before passage. I personally believe that health care reform will become a reality in 1994. The changes that have already started to occur in the health care marketplace due to the expectation of reform, not reform itself, is evidence of the momentum of this topic, and the insurance industry in the marketplace has already been turned upside down in some ways.

As an indication of my opinion about these major concerns, I offer the following statements. Number one, there is no competition in health care reform. Your comments a minute ago concerning Blue Cross and Prudential—my concern is not with Blue Cross and Prudential, but that we have more than Blue Cross and Prudential out there to compete with. There are too few companies and too few vendors in the state of Arkansas, and if we are going to have competition, we will need more players.

There is also competition, more importantly, where care is delivered. Not between the insurance companies dealing with employers, but between patients and physicians and other health care providers. Currently there is no competition in health care.

Number two, patient attitudes and responsibilities toward purchasing health care must be central to any feasible solution. Making people responsible for their health care and at least trying to understand what the costs are associated with their treatment plans is important. Right now patients and physicians do not realize what the cost is for the care that is given or that is proposed to be given.

Three, the total cost of health care is not a function of unit price of service only, but of the setting and the frequency of service, the appropriateness of actual care delivered. Too many health maintenance care efforts are focused on negotiating the lowest possible price, and that is very one sided.

Providers of health care will not alter their treatment patterns or practice patterns until known risks and potential rewards are integrated within the health care delivery system. In addition, meaningful ownership and accountability will have to be fostered

by providing health care providers with useful and credible information in order to let them compare themselves to others in their peer group.

Another important point is that payment levels between Medicare, Medicaid and private insurance systems have created such a significant cost shifting that getting everyone covered under health insurance alone will not address this cost shifting problem. All three systems, including Medicare, must be brought together in a focused and coordinated effort. When you examine the reimbursement levels of the various programs in comparison to true costs, you see the disparity that exists.

In order to give a good indication of the size of health care in the State of Arkansas, I offer some 1990 statistic estimates. Estimates indicate that 5.3 billion dollars was spent on health-related care, including research and construction in Arkansas in 1990. The breakdown of those figures helps you to understand the relative size of each payer category, or where that money was coming from.

Health care expenditures for Medicaid in 1990 was 400 billion dollars. Medicare was one billion. Again, I am rounding all these numbers. One billion dollars for Medicare. Private insurance and individual policies spent 1.1 billion dollars, a little over 20 percent of the total. Personal expenditures, out of pocket items by people paying out of their pocket, was 1.4 billion dollars, the single largest category. Research and construction, 200 million dollars. Administrative expenses, 300 million dollars. Government and other public health expenditures, 900 million dollars. In aggregate, 72 percent of these figures were spent in three global expense categories: hospital expenses, physician care, and prescription drugs.

Based on this percentage, it would breakdown as follows. 2.4 billion dollars for hospital services, 1.2 billion dollars for physician, and 360 million dollars for prescription drugs.

As you examine the state of Arkansas, in context with health care reform and in the insurance market, you cannot ignore the relative size of the existing expenditures by these payer categories. Medicaid and Medicare are in and of themselves 27 percent greater than the size of all private employer and individual policies that currently exist today.

Also one out of five Arkansans is uninsured totally. Over 40 percent of this State is below the poverty level—200 percent of poverty level, which for a family of four is approximately $25,000.

Reform of the conventional insurance marketplace cannot and will not in and of itself address these concerns. Although I am a firm believer that health insurance reform is required in the conventional sense.

Arkansas is medically underserved in 90 percent of our 75 counties. Over 50 percent of the population lives in medically underserved areas. The net result of our current delivery system indicates that too much medicine is available in some areas and too little in the rest of the state.

The insurance marketplace will change dramatically under health alliance and health insurance purchasing cooperative approaches. Under a reformed system, this will mean that alliances will be responsible for negotiating services with various health plans. This is a dramatic change for the industry in that current

type relationships exist between insurance companies and employers making decisions on behalf of their employees. Not between patients and their providers, which are for the most part semi-silent partners under the current system.

Under health care reform, alliances will need to promote competition in order to obtain competitive pricing and to slow the rates of growth of health care expenditures. In order to do that, the health plans themselves will have to be effective in providing an informational infrastructure to the providers, the people who are ordering the tests and making the decisions, and in order that they understand the quality and the cost issues relating to their treatment plans.

Such technology currently exists on a very, very limited basis. The State of Arkansas does not currently possess a large number of vendors who are capable of even implementing this system as described in health care reform throughout the state of Arkansas.

Total health care expenditures in the state averaged approximately $2,000 per person in 1990. While this looks small in context of National statistics, it is still a tremendous burden.

In order to bring about effective health care reform, there are several steps which will have to be taken during the next 4 years. We will need to re-examine the distribution of our resources to bring about significant health care reform, as mentioned here regarding guaranteed issuance, guaranteed renewability and so on.

In addition, the actual delivery of care will need to be realigned so as to more effectively use the limited resources that we have.

In the insurance marketplace in Arkansas there are very few companies doing business that offer a multiplicity of health plans, indemnity plans, point of service plans, HMOs and so on as described by the President's package. This means there is limited competition within the state with only a handful of insurance companies representing the 1.1 billion dollar industry, as listed by the 1990 statistics.

I believe that by looking at all health care systems, such as Medicare, Medicaid and private insurance and the uninsured, this is the only way we are going to be successful. Otherwise we will continue to have cost shifting, but between government programs. Of course, under the Clinton plan, Medicaid is proposed to be brought into it while Medicare has effectively been left out of it. Which for some hospitals, as you will hear later on today, is a significant issue. In the state of Arkansas, one statistic that I have quoted several times is that Arkansas leads the country out of all 50 states in that private insurance reimburses about 158 percent of true costs. That puts us number one out of all 50 states, and that is due to this cost shifting issue in part.

The CHAIRMAN. Thank you, Steve.

Mr. MADIGAN. Thank you.

[The prepared statement of Mr. Madigan follows:]

PREPARED STATEMENT OF STEVE MADIGAN, VICE PRESIDENT, SEABURY AND SMITH, LITTLE ROCK, ARKANSAS

I am pleased to be here today to address this group as a representative of the insurance industry discussion panel. I would like to begin with an explanation of my perspective as a benefit consultant. As an officer within an insurance program

management company, I have represented my clients in their jobs as benefit administrators in purchasing health care coverage for their employees. In that capacity, I have watched the insurance industry evolve into a series of cost containment mechanisms and marketing schemes in an attempt to slow the rate of growth in health care costs.

Today my comments and observations will focus on my concerns and recommendations about effective ways to improve our Health Care System.

Various legislative proposals pending before Congress will change repeatedly during the coming debates. I personally believe that Health Care Reform will become a reality during 1994. The changes that have already started to occur in the market place, due to the expectation of reform, is evidence of existing momentum of this topic.

As an indication of my opinions about the major concerns with Health Care Reform, I offer the following statements:

1. The health care market is for the most part absent true effective competition.
2. Patient attitudes and responsibilities toward purchasing health care must be central to any feasible solution.
3. The total cost of health care is not a function of unit price of service only, but of the setting and frequency of service and the appropriateness of actual care delivered. Too many approaches are focused on unit price only.
4. Providers of health care will not alter their treatment or practice patterns until known risks and potential rewards are integrated within the health care delivery system. In addition, meaningful ownership and accountability will have to be fostered by providing useful exchanges of information with the health provider community.
5. Payment levels between Medicare, Medicaid, and Private Insurance programs have created a system involving such significant cost shifting, that universal access alone cannot solve our health care problem. All three systems, including Medicare, must be brought together into a focused and coordinated effort.

These statements represent basic problems with how health care has, in the recent past, have been missing the mark on slowing the rate of growth in health care. These same concerns are also some of the reasons why many managed care efforts have not been able to flourish, or only in a very limited way, in Arkansas.

In order to give some indication of the size of our health care market in Arkansas, I offer the following estimates of 1990 expenditures.

Estimates indicate that a total of $5.3 billion dollars was spent on health related care, including research and construction, during 1990. The breakdown of these figures help us understand the relative sizes of each health care payor category:

1. Health care expenses for Medicaid amount to $400 million dollars.
2. Medicare expenditures equalled approximately $1 billion dollars.
3. Private insurance including group and individual policies amounted to $1.1 billion dollars.
4. Personal expenditures, and out of pocket items, paid by consumers amounted to $1.4 billion dollars.
5. Research and construction expenditures accounted for $200 million dollars.
6. Administrative expenses totalled $300 million dollars.
7. Government and other public health expenditures amounted to $900 million dollars.

In aggregate, 72 percent of these figures were spent in the three global expenses categories of hospital services, physician care, and prescription drugs. Based on this figure, the breakdown for those categories, out of this total $5.3 billion dollars include $2.4 billion for hospital services, $1.2 billion dollars for physician services and $360 million dollars for prescription drugs.

As you examine the State of Arkansas in the context of health care reform and in the insurance market, you cannot ignore the relative size of existing expenditures by payor category. Medicaid and Medicare are in and of themselves 27 percent greater in size than all private employer and individual medical policies combines.

Also, one out of five Arkansan's is currently uninsured and over 40 percent of the population makes less than 200 percent of our national poverty level, which for a family of four in Arkansas would be $25,348 per year of income.

Reform to the insurance market place cannot in it of itself address the concerns of this ever escalating burden.

Arkansas is medically undeserved in 90 percent of our 75 counties. Over 50 percent of the population lives in areas that are medically undeserved. The net result

of our current health care delivery system review indicates that too much medical service is available in some limited areas of the State while too little medical care is available in the rest of the State. The insurance market place will change dramatically under a health alliance/health insurance purchasing cooperative approach under a reformed system. This will mean that the alliance will be responsible for negotiating services with the various health plans. This is a dramatic change for the industry in that current client relationships exist between the insurance companies and the employers making decisions on behalf of their employees.

Under health care reform the alliances will need to promote competition in order to obtain competitive pricing, and slow rates of growth in health care expenses. In order to do that, the health plans themselves will have to be effective at providing they informational infrastructure to providers, in order that they understand the quality and cost issues related to their treatment plans. Such technology exists on a very limited basis currently. The State of Arkansas does not currently possess a large number of vendors who are capable of even implementing a system as described in health care reform, throughout the State of Arkansas.

Total health care expenditures for the State of Arkansas averaged approximately $2,000 per person per year in 1990. While these figures may appear to be relatively low, in comparison to the rest of the country, they represent a significant burden to the families that make up our population, in addition to the employers that provide jobs for our almost 1 million working citizens.

In order to bring about effective health care reform, there are several steps that will have to be taken during the next 4 years.

These actions will require an examination of distribution of our health care resources, and significant health insurance reform (as it relates to guaranteed issuance of coverage, pre-existing condition coverage, guaranteed renewability, etc.). In addition, the actual delivery of care will need to be realigned so as to address effectively the medical treatment provided to our population, given the limited resources that are realistically available.

In the insurance market place, there are very few companies doing business in the State of Arkansas offering multiple health plan options. This means that there is limited competition within the State with only a handful of insurance companies representing the vast majority of the $1.1 billion dollar health insurance industry. Because private insurance only represents 20 percent of the total reimbursed health care cost, you should consider that conventional insurance reform alone will not represent a viable solution for health care reform.

The CHAIRMAN. Norine, I want you to tell me what I am going to tell these life insurance underwriters, and all of them who sell health insurance, today at noon, to keep them from getting tired of the Government.

Ms. YUKON. Do you mean as to whether they are going to have a job or not?

The CHAIRMAN. Yes, who are they going to sell to?

Ms. YUKON. Well, I think that depends on what the final construction of the plan ends up looking like.

The CHAIRMAN. Well, under Clinton's proposal right now, what is their future?

Ms. YUKON. In another vocation.

The CHAIRMAN. You would recommend that they go into——

Ms. YUKON. I think they need to find something else to do.

The CHAIRMAN. —McDonald's?

Ms. YUKON. Frankly there is not a place for them in the Clinton plan as it is written now.

The CHAIRMAN. Will there be room for a Medigap policy in this proposal?

Ms. YUKON. Yes. Well, again, it depends if Medicare is a part of this plan or not, but there certainly would be room for supplemental policies.

The CHAIRMAN. I am talking about Medigap figuratively. I am talking about for Dale Bumpers. I will tell you something, I just

switched policies. I went to BACE but I just switched back this week to Blue Cross and Blue Shield, because BACE was going from almost $108 a month to $169 a month, and the principal difference is one has a 75 percent copayment and the other one has an 80 percent copayment. So I said, well, I would rather take the 75 percent copayment and pay $108 a month. Now those are decisions people all over the country are making every day. Steve?

Mr. MADIGAN. I have purchased a ticket for that lunch today, because I wanted to hear what you were going to say there. I will be there.

The CHAIRMAN. In that case, maybe you will not have to attend, Steve.

Mr. MADIGAN. I will say, Senator, that this issue of supplemental policies, as we have 1,800 or 2,000 insurance companies right now doing business in various states to varying degrees, they will get out of business, many of them. There will be very few players and the shrinkage is a real concern. As those companies get out of the business, there are many insurance companies that could become an investment company overnight and stop issuing new policies, but many of them will try to focus on these supplemental contracts, Medigap in the generic sense.

The CHAIRMAN. Yes.

Mr. MADIGAN. Under the Clinton plan, the proposed loss ratio I believe is 90 percent. That will not leave any compensation or money for administrative overhead to even pay agents to sell that. Also there will be too many companies going after too small of a market at one time, and that will also produce a problem, because they will be getting out of their conventional group insurance businesses and trying to get into the supplemental policy business.

The CHAIRMAN. Bob, quickly, let us take Fort Smith. I grew up in that neighborhood. So I know 20 percent of the health care delivered in Fort Smith, AR, are to people from eastern Oklahoma. Now these alliances are going to be set up by the state legislatures?

Mr. CABE. Yes.

The CHAIRMAN. So, does that mean that the Fort Smith alliance or the Arkansas alliance, depending on what Fort Smith is a part of, enters into some kind of cooperative agreement with the Oklahoma alliance? Is that the way that would work?

Mr. CABE. Well, I think that is a possibility. I think it might be a possibility that an accountable health plan could be organized in Oklahoma that would actually contract with one of the hospitals in Fort Smith and providers in Fort Smith to provide services to those Oklahoma residents who want to come across the border.

The CHAIRMAN. Presumably the basic package is going to be the same in Arkansas and Oklahoma.

Mr. CABE. Sure is.

The CHAIRMAN. I can tell you that has been a concern for them. And I am thinking about West Memphis.

Ms. YUKON. Exactly.

Mr. CABE. Right.

The CHAIRMAN. I am thinking about Texarkana that actually services 4 states. I am not saying that those problems are insurmountable, but I am saying they are difficult. I just wanted to know how we are going to cover that. You are going to have pieces

of cities, pieces of counties and they are going to have to have all kinds of cooperative understandings.

Ms. YUKON. That is one of the problems with 50 different states creating 50 different bureaucracies.

The CHAIRMAN. Norine, let me just carry that one step further. Let us assume that in Oklahoma, the person or the company who bids, let us say if you have an Oklahoma alliance, let us say a company that bids on that takes into consideration health care costs in Oklahoma, not Fort Smith, Arkansas. Let us assume further that health care in Fort Smith, Arkansas is 25 percent higher than it is generally in Oklahoma.

Ms. YUKON. That is not going to induce them to go across the border.

The CHAIRMAN. Pardon?

Ms. YUKON. That is not going to induce them to cover people in Arkansas.

The CHAIRMAN. That is what I am saying.

Ms. YUKON. But one of the issues involved in this is community rating, and adjusted community rating, that would be adjusted by geography. So, that would presumably take into account that health care costs are higher in one location than they are in another.

The CHAIRMAN. You know, I am glad you are not a member of the legislature. You talk about a donnybrook, that is going to be a donnybrook when the legislature starts consigning the geographical boundaries of these alliances.

Ms. YUKON. I am glad you are sensitive to this issue, because these are the very details that can really break apart a system that sounds good on paper once you get into the reality of trying to pragmatically produce something that works for people.

The CHAIRMAN. Well, you have all testified extremely well. I wish we had more time. We have one more panel I want to get to before lunch. Thank you very much.

Mr. CABE. Thank you.

The CHAIRMAN. Thank you.

Our fourth panel this morning is Dr. Charles Feild, Chief of Community Pediatrics, Children's Hospital. Dr. Harry Ward, chancellor, UAMS. Dr. Thomas Feurig, president, St. Vincent Infirmary. Roger Busfield, president, Arkansas Hospital Association. That is a lot of power.

I am sorry, Lee Fraizer is going to be testifying instead of Tom Feurig.

The CHAIRMAN. Dr. Feild, you are first on my list, so please proceed.

STATEMENT OF DR. CHARLES R. FEILD, FELLOW, AMERICAN ACADEMY OF PEDIATRICS AND ASSOCIATE PROFESSOR OF PEDIATRICS, CHIEF, COMMUNITY PEDIATRICS AND PUBLIC POLICY, UNIVERSITY OF ARKANSAS FOR MEDICAL SCIENCES AND ARKANSAS CHILDREN'S HOSPITAL

Dr. FEILD. I am Dr. Charles Feild.

The CHAIRMAN. You are such a hot doctor, how do I get rid of this cold?

Dr. WARD. That is what we have been talking about. We have got the same one.

Dr. FEILD. I loaned Dr. Ward a cough drop.

I am a pediatrician, faculty member of UAMS, and a medical staff member of Arkansas Children's Hospital. I started work at Children's Hospital as a junior medical student in 1975. I left Arkansas twice and returned twice to continue to work there. I have seen the hospital go from 90 beds to 240 beds.

I want to talk today about children's health care needs in terms of the current situation in Arkansas as well as the reform proposals under consideration in Washington. I will also mention some efforts of the UAMS Department of Pediatrics and Children's Hospital that I believe hold promise as part of any broad changes in health care. I hope to make a case for Arkansas and other states to have the option to form one statewide single health plan specifically designed for children.

For children to receive adequate health care there must be both financial and systems access to care. I will not belabor you today with statistics on infant mortality, low birth weight, and low immunization rates. I know if you are not familiar with those, Mrs. Bumpers and Mrs. Clinton are.

Like any commodity, health care is a cost that ultimately must be borne somewhere. In Arkansas 22 percent of children have no health insurance of any kind. These uninsured children predominantly live in young working families, parents in entry level jobs that lack benefits, or if benefits are available they are too expensive. Health care for these children is an out of pocket expense for families with very limited disposable income. Children's Hospital last year, for example, delivered 58.6 million dollars in uncompensated care, predominantly to working families.

The CHAIRMAN. That was a percentage of the total. What was the percent?

Dr. FEILD. I do not know. Blanche Moore of Children's Hospital, are you back there?

The CHAIRMAN. Blanche, do you know offhand?

Ms. BLANCHE. It is about 10 percent.

The CHAIRMAN. 10?

Dr. FEILD. Ten percent. Outpatient care for these uninsured children is often delivered in emergency rooms, where families have learned, as you have mentioned earlier, they cannot be turned away. I was the emergency room director at Children's Hospital in the early 1980s and continue to work there. An emergency room is a wonderful place to care for a sick or injured child, but it is no substitute for preventive care with a physician who knows the child and the family.

The American Academy of Pediatrics has developed a concept of the need for a medical home for every American child, and has established a Community Access to Child Health, or CATCH program to further that goal at local levels across the country.

For children who have private insurance, it is estimated that only 6 percent of them are adequately covered for the preventive and outpatient primary care that is what most children really need. Those services in some instances can be covered for as little as $9.50 a month.

I would like to bring you up to date with a program that you, Senator Bumpers, were instrumental in developing. The Get Smart school enrollment based health insurance project has become a national model.

Our group here in the UAMS Department of Pediatrics and College of Agriculture in Fayetteville with your support received a grant to develop a school based health insurance program in the Elaine and Eudora School districts. As you know, those are two of the poorest school districts probably anywhere in the country.

We are in the third year of coverage for 600 previously uninsured school children. The program utilizes local pediatricians and providers with support from myself and many other pediatricians from the Department of Pediatrics. There is no copay or deductible to the family. This has proven to be a very low cost program.

The rebate on premiums from the underwriter was large enough to allow us to add dental coverage at no additional cost to the program. Many of these children had never seen a dentist, and some are now going to school for the first time without a toothache.

I want to share with you the most surprising lesson I learned from that program. Many of these children have never had the type of regular wellness visit or checkup that all of us expect for our own children and grandchildren. We include a check up as a part of coverage, and promoted it highly within the community and schools. We anticipated that families would choose a local physician, but offered to see children at the school if the family so desired. Senator, 370 of the 600 children had a check up that first year, and that level of participation in the wellness program compares favorably nationally.

All but one family chose to have their child seen at school rather than a private doctor's office. What does that mean? I think that families have not had previous experience with good true preventative primary care, therefore they were comfortable with the convenience of school based health. I also think that these poor working families had work schedule and transportation problems and that they need access to programs such as this. These families continued to use local physicians for significant illnesses, trauma and chronic problems.

I believe there is a message here about effective partnerships between children's hospitals, physicians, and school health. A child's medical home may be a school by day and a different site or provider after hours. The challenge is to find a way to develop and formalize that partnership and allow for adequate record keeping and record sharing.

We believe this program has national significance. It has been published places, including the Wall Street Journal.

The current proposal for national health care reform is based on health alliances to regulate and broker health care, as we have heard. Each state will determine how many alliances it needs. Each alliance must offer a variety of plans. A New England Journal of Medicine article earlier this year suggests that rural states such as Arkansas will have difficulty providing true competition in rural areas. Indeed, in many areas, I hear from my colleagues that they need cooperation rather than competition.

At the direction of the Health Care Access Council, some of our group worked on a Robert Wood Johnson supported effort to design a statewide system of funding access to child health care. The Access Council earlier this year was superseded by the Governor's Health Reform Task Force and the Health Resources Council, and the focus of both those groups was broadened to health care reform as a whole.

However based on work of our group on the original goal of the child health system and the current proposals in Washington, Arkansas is in a position to form a single Accountable Health Plan dedicated to the needs of pregnant women and children. The Children's Accountable Health Plan allows care and planning from conception and delivery to the school clinic and hospital.

A provider network dedicated to children involves provides and services different from those for adults. As we have seen, schools have a relevant health care delivery, because that is where the children are. A provider network for children that includes schools can provide a needed emphasis on nutrition. We have directed health screens on all the children that enroll in Head Start in Pulaski County for the last 4 years, and each year we find 20 percent, one child in five is iron deficient and anemic. This is particularly disturbing for two reasons. These children are from families that are eligible for the WIC program. WIC targets anemia as much as height and weight. These children soon after graduating from WIC are found to be iron deficient and anemic already.

Also research shows that even mild iron deficiency decreases the ability of children to learn and pay attention in school.

Children also have developmental needs that overlap health care. Arkansas has played a role in providing that link through the Infant Health Development program that showed infants that received an early intervention program had IQ scores at the end of that program 8 to 13 points higher than a control group.

Again a health plan focused on the needs of children can provide such services.

Why not mandate these and other services and allow each more traditional health plan to provide it? As I said above, there are questions whether the rural State can provide competition for routine medical care and more traditional plans, much less more sophisticated services for children. Much of the services available for children have been developed and operated in not for profit organizations, such as schools, public health clinics, community health centers and teaching hospital. Private health care for children on the out patient basis is delivered mostly by pediatricians and family physicians. Those physicians deliver office based care and are two of the lowest paid groups of physicians in the country. There is a need for more of those practitioners in Arkansas and indeed in the country.

I obviously strongly support the need for survival of the children's hospitals. The majority of patients in any children's hospital are under age two. These children need much more care than adults just for feeding, dressing and changing. The size range of pediatric patients from 12 ounce preemies to 250 pound high school football players requires a wider range of equipment than for a general hospital. Any children's hospital cannot survive by being

limited only to true tertiary patients, unless it involved the primary and secondary care of the child population at large.

I fear that the needs of children will be lost. Again, in the complexity and rhetoric of the reform debate unless we can deal with them as a separate entity. I hope you and others will consider children's health care needs as a priority, in fact as a special case as health reform moves through Congress. Thank you.

The CHAIRMAN. Charles, you'll be interested in knowing, I have given some of those figures in committee hearings and on the floor of the Senate many times. They are really compelling. Of course, the other thing is as Chairman of the Agricultural Subcommittee on Appropriations, I also have jurisdiction over the WIC program.

Dr. FEILD. I knew that.

The CHAIRMAN. And the WIC program, of course, provides a return of more than $3.50 for every dollar we are spending. That is the kind of investment the United States ought to be making. Dr. Ward?

STATEMENT OF DR. HARRY WARD, CHANCELLOR OF THE UNIVERSITY OF ARKANSAS FOR MEDICAL SCIENCES

Dr. WARD. Thank you, Senator. I submitted my testimony to you, so I will try to summarize my summary. What I had planned to do is to talk about some of the general concepts and then some of the specific areas as they affect the Academic Health Center.

First, I strongly support the Health Security Act. I think it is excellent. I think the general outline is excellent. I would emphasize two points.

One, it is very critical that the concept of universal coverage be an intrinsic part of this plan. It shouldn't be a phase-in, it really should be at the start. I think there is no way to really handle the health care cost unless we have the concept of universal coverage.

Second, I am comfortable with the concept of the health alliances. I think the health alliances should be put at the State level. They will then have strength and they will be empowered to review each accountable health plan. They can control some costs, but in addition they can prevent the cherry picking that is going on.

Let me quickly move into some of the unique things about the Academic Health Center, particularly in the state of Arkansas. Historically Academic Health Centers have determined the number and the mix of our interns and residents. We have been reimbursed partially through Medicare through the Direct Medical Education subsidy and the Indirect Medical Education subsidy. Under the Health Security Act, a national council will be established to set these goals with a goal of 55 percent primary care by the year 2002. Although this is going to cause some problems, I support it. We need to increase primary care physicians.

In order to fund this change, the Health Security Act transfers both the Direct Medical Education and the Indirect Medical Education into a central pool and adds a set aside of 1½ percent of all the health insurance premiums to this central pool. This concept is very central and must be preserved.

The CHAIRMAN. Well, Dr. Ward, are you saying that is a provision in the bill now?

Dr. WARD. Yes, it is.

The CHAIRMAN. I was not familiar with that, one and a half percent?

Dr. WARD. One and a half percent. And it is a set aside and it will be then used for the educational cost and for academic health centers, to subsidize and to unbundle the cost of education from our cost. And this will be very important to the University Hospital, to Children's Hospital.

So, from all the dollars of all of the health insurance programs, the accountable health programs, 1½ percent of those premiums would go to a central pool to help for the educational cost. And as you work through this at Congress, I would hope that you would focus onto this as an important requirement.

Included in the funding, then, from this cost would be this shift of 55 percent primary care physicians. In addition there would be a 200 million dollars set aside for the training of nurse practitioners and physician assistants. And again, that is an absolutely vital thing for the infrastructure of the program.

A critical area in the Health Security Act for Arkansas relates to the public health section. We have already heard some testimony to this, but the public health section of the Health Security Act is very extensive. It ranges from page 540 to page 650, about 110 pages of initiatives. In these sections is an excellent new agenda for AHECs, for community health centers, for rural issues, for preventative medicine, for health promotion issues, for transportation issues, which are so important in Arkansas. All of these initiatives are to be funded by what is called the Public Health Service Initiatives Fund. Unfortunately there is no funding outlined for the Public Health Service Initiatives Fund. It is my understanding from Secretary Lee that at the last moment this was eliminated. It must be reinstated. Of all the things going to affect Arkansas, a public health initiative as an intrinsic part of this National Health Security Bill is absolutely vital.

I would suggest that another ½ percent set aside should be considered as a source of funding for all the public health initiatives. That would bring in about 3 billion dollars. It would be a national pool that would then rise or fall as a reflection of the health care service delivery dollar, and that, in fact, would then be added to the 1½ percent that is already in the bill for a total of 2 percent then of the work force issues, the academic health care issues, and the public health infrastructure for this country. Thank you.

[The prepared statment of Dr. Ward follows:]

PREPARED STATEMENT OF DR. HARRY WARD, CHANCELLOR OF THE UNIVERSITY OF ARKANSAS FOR MEDICAL SCIENCES

I am Dr. Harry Ward, Chancellor of The University of Arkansas for Medical Sciences. I am pleased to have the opportunity to discuss The Health Reform Agenda and, specifically, the proposed American Health Security Act. I recognize that some aspects of the plan are still being developed—but let me speak to the general concepts and then to some specific areas that affect the University of Arkansas Academic Health Center and The State of Arkansas in general.

To begin with, I strongly support the general concepts of the Health Security Act. It addresses the majority of the problems that I spoke about last year when I presented to your Small Business Hearing Committee, specifically:

(1) It provides universal coverage. This is absolutely critical if we are to address issues of cost shifting, indigent care, access for our citizens, etc.

(2) The system of health alliances should prevent cherry picking by health plans and should significantly reduce the unbelievable administrative overhead that faces small businesses when they try to join a health plan. As you remember, it is estimated that between 15 and 30 percent of the health care insurance premium that is charged a small employer may be the result of administrative overhead.

(3) The American system of health insurance has been based on a shared employer-employee basis. It is estimated that today 85 percent of all covered Americans have a shared insurance program. The Health Security Act is based on this concept—and that makes sense to me. The problems are obvious:

(A) An 80-20 percent may be higher than many industries today. I think a 50-50 percent is more common.

(B) And, without question, there are some small businesses that do not provide health insurance—and they will be mandated under this plan. It is important to remember that this is a small number. They will need some assistance to phase it in—and, in fact, some of the phase-in can occur through the Health Alliance Program and the government subsidy that is available on an income basis for the employees. I think Congress will need to work a bit on this issue and make appropriate changes to allow a smooth transition.

(4) The proposed plan preserves the role of multiple payors, insurance companies, HMO's, PPO's and fee for service approaches. Although they will function under a health alliance—which fundamentally is a public/private service commission—at least, choice is preserved—and the basis of the American system of care is retained.

In summary, the broad concepts of the plan attempt to utilize the foundations of our medical system—employer/employee shared responsibility, choice with many plans and a central role for insurance carriers—and add the absolutely central concept of universal coverage.

Now let me say a few words about academic health centers and unique issues in Arkansas.

Historically, academic health centers have determined the number and the mix of our interns and residents. We have been partially reimbursed through Medicare via the Direct Medical Education subsidy, and the Indirect Medical Education subsidy. Under the Health Security Act, a national council will be established to set these goals—with a 55 percent primary care goal by the year 2002. Although this is going to cause some problems—I support it—we need to decrease the specialists and increase primary care. In order to fund this change, the Health Security Act transfers both the Direct Medical Education and the Indirect Medicare Education subsidy into a central pool—and adds a tax of 1.5 percent of all health insurance premiums to this central pool. This concept is critical and must be supported. In addition, this form of funding for educational costs will allow medical centers to unbundle their charges, and, thus, reduce charges to be more competitive with the private hospitals. It is my understanding that $200,000,000 of this pool will be used to expand primary care MD's, physician associate programs, nurse practitioner programs, and minority programs. All of this is very important.

The academic health centers of this country will continue to need special attention and assistance. Those people that fall through this new safety net will continue to use our hospitals. The development of high technology, new technology, issues of quality, as well as education of all health professionals must continue to be our role and mandate.

A critical area in the Health Security Act for Arkansas relates to the public health section—from pages 540 to 650. In these sections, an excellent new agenda for health promotion, preventive medicine, rural issues, national health service corps, transportation, community health centers, AHEC's, etc.—all issues vital for Arkansas are beautifully outlined. They are to be funded by the Public Health Service Initiatives Fund. Unfortunately, nowhere in the plan is there any description of the origin of this fund. It is my understanding that this "pool" of funds was removed for fiscal reasons during the final stages of the plan. It must be re-instated. I would suggest that an additional ½ percent should be taxed on all premiums for these important programs. If added to the 1.5 percent for workforce and academic

health centers, this would represent a total of 2 percent of all premiums being devoted to public health, education of the workforce, and preservation of academic health centers—with 98 percent coming back to the alliances for direct reimbursement of providers and administrative costs.

The CHAIRMAN. Thank you, Dr. Ward. That is really interesting testimony. We will come back to it in just a moment. Lee, since you were substituting for Dr. Feurig, if you would, state your name and position so that we have it on the record.

STATEMENT OF LEE FRAIZER, EXECUTIVE VICE PRESIDENT, ST. VINCENT INFIRMARY MEDICAL CENTER

Mr. FRAIZER. Yes. Thank you, Senator. My name is Lee Fraizer, executive vice president, St. Vincent Infirmary Medical Center. I am speaking on behalf of Tom Feurig, our president, to basically indicate our support for the Health Security Act.

We have already submitted written testimony and I would just cover a few highlights of that testimony.

In response to some of the other speakers before this panel, to give you some idea of what the private hospital is involved in. We write-off at St. Vincent, for instance, roughly 130 million dollars a year and it is increasing. Of that 130 million dollars, approximately 80 million dollars is from discounts, alliances, et cetera, and even through Medicare, private insurance, or whatever. Basically these are discounts off of charges for which we do not have any reasonable expectations of collecting.

In addition there are some 20 million dollars in actual bad debt for services which have been rendered for which no payment can be received. Last, there is another category that represents about 12 million dollars in what we will call charitable care in which there is a cooperative experience between the doctor and the hospital to render care to someone who we know will not be able to pay or do not have any kind of coverage.

The concerns are obvious in terms of health care. The high cost that is brought about by regulations—greed, unfortunately, I think is a very key element in the rising cost and increasing cost of health care. Obviously the whole incentive is now to pay for sickness rather than wellness.

The hospital industry is labor intensive as well as high-technology intensive, and certainly has an impact on the growing cost of health care. We believe, however, in spite of all of this, that the Health Security Act represents the best method to counter and to help provide certainly a breakthrough and provide some incentive for a health care system.

Of note, we feel an integrated delivery network as a part of the solution is essential. We must take leadership roles in cost containment by aligning economic incentives for hospitals and physicians together. Far too often the two have gone separate courses in which there has not been parity in terms of incentive for both hospitals and for physicians.

We also believe that Medicare and Medicaid should be included in the overall plan. As you know at this point Medicare is not a part of the overall plan, but it certainly ought to be.

Finally as we look at the plan, we believe that incentives for wellness through capitation can be a major incentive for wellness

and a wellness program. We believe more should be done in terms of tort reform. Even if we deal with it by just simply providing a penalty for frivolous lawsuits, for instance. Education and behavior modification must be a key as we look at wellness and educating our public in terms of how to use the health care system.

Finally our concerns, in summary, about funding mechanisms. Obviously we do not know until the bill passes, how and to what extent funds will be used to pay for the Health Care Act. Hospitals are also employers and would range from very small, less than 100 beds, all the way up to 700–800 beds in this state, with 2,000 to 3,000 employees each. So, we represent a major block in the employer section.

We feel that this is obviously a public health issue, as well as a health care issue, and should not be treated segmentally just with the providers. It is a formal global impact as we look at the effects of health care on our population. There is concern about the National health care board and the layering of bureaucracy. This is something that must be addressed and will be addressed in the Congress. Certainly as you look at the complexity of a 250 page document, as you begin to change one segment of the plan, it will have major effects on the other segments.

On the positive side, obviously universal coverage, employability and the ability to have capitation in the plan are very positive and will lend itself to ultimate preventive medicine and the joining of the public health efforts which are already underway. We applaud the Arkansas Health Department and the things that it is doing in this state. In many cases it is the first and only level of health care providers. We feel that this kind of plan will lend itself for more partnering of the private side along with the UAMS and other providers in the state, both private and public in terms of providing a cooperative and collaborative method in offering solutions to the health care problems. Thank you.

[The prepared statement of Mr. Feurig follows:]

PREPARED STATEMENT OF THOMAS L. FEURIG, PRESIDENT & CEO, ST. VINCENT INFIRMARY MEDICAL CENTER

Good morning, Senator Bumpers, ladies and gentlemen. I am honored to appear before this hearing as we begin to determine how our Nation's health care system will be reformed.

My name is Tom Feurig and I'm President and CEO of St. Vincent Infirmary Medical Center. St. Vincent is a full-service, Statewide medical center with a 105-year history of providing health care services to the people of Arkansas.

On September 22, President Clinton outlined for us his agenda for national health care reform. I believe the President cares deeply about reform and has issued a mandate to providers and consumers to develop collaborative and creative solutions for a broken system.

It had to be plain to everyone who heard the President's address that "universal access" to health care is non-negotiable. Under whatever system emerges, all Americans will have equal access to the system.

This bold and compelling component of the reform proposal speaks directly to the mission and values of the Sisters of Charity of Nazareth upon which St. Vincent Infirmary Medical Center was founded.

Health care facilities were established for the public benefit, to serve the communities that helped create them. We believe that:

- health care is a service, not a mere commodity to be exchanged for profit,
- public policy must serve the common good,
- every person is the subject of human dignity,
- the needs of the poor have a moral priority,

- there must be responsible stewardship of resources,
- tasks should be performed at appropriate levels of organization.

Building a shared vision of the future and identifying and challenging outdated modes of thinking are responsibilities that we all share.

We must focus our care and concern for the health, wellness and well-being of persons, communities and society.

We must become leaders in the movement toward a redesigned U.S. health care system that is just and equitable.

We must create innovative ways to provide continuity, stability and collaboration in our communities.

INTEGRATED DELIVERY NETWORKS

In spite of life-saving and life-extending capabilities in acute care hospitals that are the envy of the world, the Nation's current health care system costs too much, is fragmented, and lacks adequate access for many people. The system's failure has many symptoms. For example: outbreaks of vaccine-preventable diseases; inadequate primary care for the poor; medical arms races where costly technology is purchased for prestige or other competitive reasons rather than community needs; and a lack of coordination.

Integrated Delivery Networks are a Part of the Solution

The reaction to system failure from business, consumers and health care providers has converged to create the political will to change the basic way in which health care is delivered. The development of networks is an important component of the solution to these programs.

We must take leadership roles in cost containment by aligning economic incentives for hospitals and physicians. Integrated delivery networks provide opportunities for better negotiation of prices with payers, participate in local decision-making to streamline administration, increase clinical efficiency, and reinvest efficiency savings locally for the benefit of the community.

We must include Medicare and Medicaid in the overall reform plan. Medicare payments make up 40 percent of hospital revenues nationally. At St. Vincent that percentage is even higher. Further reductions could severely affect the ability of providers to deliver quality care.

As part of our dedication to serving the whole person, we must honor the connections between body, mind and spirit. Our commitment to the community involves more than acute care from within the walls of our institutions. We must continue our progress in the network arena to ensure that problems are averted or treated early and that needed services are efficiently provided.

Our commitment is a community-based focus on health status and wellness. It includes essential incentives for economic discipline and continuous quality improvement, and offers a new emphasis on wellness, rather than sickness. It is driven by values that insist health care must be seen as a basic human right in the context of public policies that serve the common good.

Thank you.

The CHAIRMAN. Thank you, Lee. Roger?

STATEMENT OF DR. ROGER BUSFIELD, JR., PRESIDENT AND CEO, ARKANSAS HOSPITAL ASSOCIATION

Dr. BUSFIELD. The hospitals of Arkansas, Senator Bumpers, as well as the hospitals throughout the Nation recognize the need for health care reform. Reform is needed and we need to focus upon just what we are going to reform and how.

All of us want equal access to health care. Most of us want to be assured that we will not be denied care because of an inability to pay. And we want that care to have quality and be affordable.

Much time has gone into developing the Clinton proposal and it has much merit and should be the starting place for all discussion and debate on health care reform.

The Clinton bill does not include Medicare in the plan. It does allow the states to exercise the option of including Medicare as well as Medicaid. Clinton administration officials have acknowl-

edged the designers of the plan wanted to include Medicare from the very start, but were reluctant to do so for fear that the elderly would oppose the legislation, much as they did the catastrophic coverage that was quickly repealed several years ago because of its cost to the elderly.

Medicare and Medicaid must be included in any program addressing health care reform. All of us should be included in the program. And that is the universal coverage Dr. Ward was referring to. There should be no exclusions. We must assure the elderly that they will not lose the freedom of choice they now have when selecting providers, though not all providers today treat Medicare and Medicaid beneficiaries by choice. We must explain to this same group of elderly, of which very frankly I am a member, that all of us will benefit by being in the same program.

Providers must have a level playing field. Varying or different levels of reimbursement for the same medical procedures performed by the same providers must not be allowed to continue. Medicare historically has not paid for the cost of providing care. Yet many proposals, including the Clinton plan, are designed to achieve savings by cutting the cost of the Medicare program.

If we are to have reform, let us start by declaring that all groups will receive the same level of care, regardless of who is financially responsible for the care of the patient, whether under the health care reform program, the Medicare program or the Medicaid program to the poor. And let us also declare that any program adopted must be financially stable and pay for the actual cost of providing the care. Yes, we should address cost, but cutting cost should not be confused with cutting quality or quantity of needed or necessary services.

Congress can help us control cost by addressing what has driven up our cost, and it has been mentioned here today. Uncompensated care that has now cost shifted to the paying patients; unnecessary diagnostic procedures because a physician is afraid of a possible malpractice suit; the inability of hospitals and physicians to collaborate more closely and cut costs because of restrictive antitrust laws; and a growing mountain of regulations that inhibit and stifle the delivery of care. And we could go on.

In summary, equal access can be achieved, but it must be applied to all groups and all groups must be included in any health care plan finally adopted.

Also, Congress must ensure freedom of choice for every patient covered. And as Congress debates the various plans, it must remove unnecessary restrictions that have inhibited the delivery of quality care.

I believe I speak for all hospitals when I say that we do not want to be obstructionists while the system is being developed, we want to be a player and we want to continue to be part of the debate. In fact, health care reform as proposed by the American Hospital Association calls for more radical changes than any other proposal.

On a personal level, we must prevent the denial of coverage because of any preexisting condition. We must bring an end to cherry picking where companies are allowed to choose only good risks. I could have retired 2 years ago when I was 65 if I could have found coverage for my wife who was fighting lung cancer. You see, when

one spouse is eligible for Medicare and the other is not because he or she is younger, the eligible spouse finds that he or she cannot retire. He or she must continue to work, so that the primary coverage for the spouse will be provided by the company's or the employer's group health care plan. This situation, in my opinion, must be addressed before we solve any plan that is ultimately adopted. My wife lost her battle. The cost of her care, especially the cost of the pharmaceuticals used in her chemotherapy was astronomical. Her bills came to $62,000, and about $20,000 of that was for pharmaceuticals. I believe that those who have had loved ones in this situation, in this position, will strongly support the reform of our health care system and whatever pain it may cause.

Thank you. I will be happy to answer any questions.

[The prepared statement of Dr. Busfield follows:]

PREPARED STATEMENT OF ROGER M. BUSFIELD, JR., PH.D., PRESIDENT AND CEO, ARKANSAS HOSPITAL ASSOCIATION

Senator Bumpers, I am Roger Busfield, President and CEO of the Arkansas Hospital Association. I am grateful for this opportunity to testify at this hearing.

The hospitals of Arkansas, as well as the hospitals throughout the Nation, recognize the need for healthcare reform. We should not argue that reform is needed. It is. We need to focus upon just what we are going to reform and how.

All of us want equal access to healthcare. Most of us want to be assured that we won't be denied care because of an inability to pay. And we want that care to have quality and be affordable.

The various approaches that have been introduced so far in Congress have addressed everything from access to freedom of choice and to all of the matters of concern of the people.

Much time has gone into developing the Clinton proposal and it has much merit and should be the starting place for all discussion and debate on health care reform.

The Clinton bill does not include Medicare in the plan. It does allow the States to exercise the option of including Medicare as well as Medicaid. Clinton administration officials have acknowledged that the designers of the plan wanted to include Medicare from the very start, but were reluctant to do so for fear that the elderly would oppose the legislation much as they did the catastrophic coverage that was quickly repealed several years ago because of its cost.

Medicare and Medicaid must be included in any program addressing health care reform. All of us should be included in the program. There should be no exclusions. We must assure the elderly that they will not lose the freedom of choice they now have when selecting providers, though not all providers today choose to treat Medicare and Medicaid beneficiaries. We must explain to this group of which I am a member that all of us will benefit by being in the same program. Providers must have a level playing field. Varying or different levels of reimbursement for the same medical procedures performed by the same providers must not be allowed to continue. Medicare historically has not paid for the cost of providing care, yet many proposals, including the Clinton plan are designed to achieve savings by cutting the cost of the Medicare program.

If we are to have reform, let us start by declaring that all groups will receive the same level of care regardless of who is financially responsible for the care of the patient—whether under the healthcare reform program, the Medicare program or the Medicaid program for the poor. And let us also declare that any program adopted must be financially stable and pay for the actual cost of providing the care. Yes, we should address cost, but cutting cost should not be confused with cutting quality or quantity of needed or necessary services.

Congress can help control costs by addressing what has driven up our costs—uncompensated care that is now cost shifted to the paying patients, unnecessary diagnostic procedures because the physician is afraid of a possible malpractice suit, the inability of hospitals and physicians to collaborate and cut costs because of restrictive anti-trust laws and a mountain of regulations that inhibit and stifle the delivery of care. We could go on.

But in summary, equal access can be achieved, but it must be applied to all groups and all groups must be included in any health care plan finally adopted. Congress must assure freedom of choice for every patient covered. And as Congress

debates the various plans it must remove unnecessary restrictions that have inhibited the delivery of quality care.

I believe I speak for all hospitals when I say that we don't want to be obstructionists as the system is being developed. We want to be a player, to contribute to the debate.

In fact, health care reform as proposed by hospitals calls for more radical change that any other proposal.

On a personal note, we must prevent the denial of coverage because of any preexisting condition. We must bring an end to "cherry picking" where companies are allowed to choose only good risks.

I could have retired 2 years ago if I could have found coverage for my wife who was fighting lung cancer. You see, when one spouse is eligible for Medicare and the other is not because they are younger, the eligible spouse cannot retire. He or she must continue to work so that primary coverage for the spouse will be provided by a company's group health care plan. This situation must be addressed and solved in any plan that is ultimately adopted.

My wife lost her battle, but the cost of her care, especially the cost of the pharmaceuticals used in her chemotherapy was astronomical. Her bills came to $62,000. About $20,000 of that amount was for pharmaceuticals. I believe that those who have had loved ones in this position strongly support the reform of our healthcare system.

Thank you. I will be happy to answer any questions.

The CHAIRMAN. Roger, let me say first of all, that is a very powerful statement. You are very courageous on the Medicare issue. If you were up for reelection, you probably would not say it. Medicaid, as you know, is included in the President's plan.

Dr. BUSFIELD. Yes, sir.

The CHAIRMAN. And Mrs. Clinton has said Medicare has been given a temporary reprieve, but that it most certainly must come under the plan at some point in the future.

Dr. BUSFIELD. Senator, I conducted a town meeting in Danville, AR the other night. I think that if we take the message to the elderly, the AARP members——

The CHAIRMAN. I could not agree with you more on that.

Dr. BUSFIELD. —that we could convince them.

The CHAIRMAN. You are absolutely right.

Dr. BUSFIELD. But we cannot avoid it.

The CHAIRMAN. Yeah. I'll tell you something, I had talked about the so-called single payer system. There is just a rejection of that because of fear of a big bureaucracy and you do not ever overcome that. It is like the National Rifle Association saying, the fact that you cannot buy an AK-47, even though you are an escaped lunatic means they are going to try to take your hunting rifle away from you.

It reminds me of one time Abraham Lincoln asked the question how many legs does a dog have if you call its tail a leg? The answer is four, because calling it a leg does not make it a leg. And that is what we deal with all day every day, these presumptions. The people on Medicare are terrified of any kind of change. They may not even like it the way it is right now, but they are terrified of change.

I can tell you, the cost is probably the number one thing driving this machine. Cherry picking is number two. Preexisting condition number three. Dr. Ward and Bill Walsh heard me say many times, I have carried policies on my daughter, Brooke, on two or three separate occasions for a year, carried two policies to make be sure she did not get caught in the preexisting condition trap. For a civil-

ized country to allow that is outrageous. As a matter of fact, there are so many things like that that are just as outrageous.

But people want the deficit brought under control. The fastest growing item that is bankrupting the Federal Government is health care cost. 17 cents of every dollar, 17 percent of Federal expenditures now is for health care. 22 percent of all the total 6 trillion dollars in health care that we are going to expend in 1993 and 1994 picked up by the Federal Government. So, there is another place where people are paying for it, it is just a hidden cost, it is being taken out of their income tax so they do not know how much of it.

But I especially appreciate, Dr. Ward, your very strong commitment to this bill. Let me just ask you one question, then I am going to have to run, but you made a calculation that if we set aside ½ of 1 percent of this fund, that totals about 3 billion dollars——

Dr. WARD. Yes, sir.

The CHAIRMAN. —for public clinics. Now, I can tell you, I probably would not even vote for the bill unless this question of community and public health is taken care of in this bill, that is how strongly I feel about it. I also think it has probably the highest cost benefit ratio of any health dollars we spend. But I wanted to ask you to compute 1½ percent to be set aside for the academic community, and that comes to around 9 to 10 billion dollars.

Dr. WARD. Yes.

The CHAIRMAN. Now, what does that supplant that the Federal Government is now paying for at UAMS, for example?

Dr. WARD. Well, that supplants its share of the graduate medical education costs of the intern residents' salaries, and then the teaching cost of the faculty of all the hospitals that have residents. And so, that 9 billion dollars would represent just basically the same amount of dollar that we currently are getting through the Medicare Direct Medical and Indirect Medical Education.

The CHAIRMAN. Well, let my give you an additional statistic, and this has been true—excuse me, go ahead.

Dr. WARD. Now, let me just add one thing. I agree with Mrs. Clinton when she says if the Government is going to pay for house staff stipends, then we should have a right to say what kind of doctors we are going to train. Now, you know, the medical faculty and the AMA is not really very supportive of that. But I think that, in fact, if the Federal Government will continue to reimburse hospitals and universities for their educational program, then in fact, I think a requirement of 55 percent primary care physicians makes sense, and reducing the specialty care down to 45 percent.

The CHAIRMAN. Dr. Ward, 70 percent of the physicians in Canada are internists and general practitioners, 30 percent are specialists. In this country that is precisely the reverse, 70 percent of the doctors in this country are specialists, 30 percent are generalists.

Dr. WARD. Yes, sir.

The CHAIRMAN. What should we be striving toward?

Dr. WARD. I really think we should be around 50/50.

The CHAIRMAN. Do you agree with that Roger?

Dr. BUSFIELD. Sure do.

Dr. WARD. I think we would be all right probably in fact, if we were 60/40. I think, in fact, a number of the specialists are doing

primary care. You know, I am a general internist as well as a hematologist and as a hematologist when I was actively practicing, about 25 percent of my work was still taking care of the general medical needs of my patients. I do not think it is quite fair to say that a specialist does no primary care. I think we would be all right at a 60/40. I really think 50/50 would be much better.

The CHAIRMAN. We could sit here for a long time and talk about how we go about achieving that, and I wish we had time to do that. Lee, did you want to comment on that?

Mr. FRAIZER. Not to comment on that, but just to add a note that the allied health professionals also need to be included and remembered as we look at the whole funding mechanism. Representative John Miller this morning spoke to that issue and it is certainly very true in the hospital community of looking for the nurse practitioners, of looking for the occupational therapists, of looking for all of those people who not only in the hospital but also out in the rural areas provide the back bone in many cases for the first line delivery of health care. If we are talking about delivering health care at low cost, we are talking about good quality, if not high quality, many times those are the people that we need at the first line levels and those are some of the people right now that we are not training enough of in the state of Arkansas.

The CHAIRMAN. Let me ask all of you, why is the AMA so seemingly hostile toward this idea of nurse practitioners and additional responsibilities for nurse practitioners, physicians' assistants and so on? Is it a turf fight or do they have legitimate reasons for being concerned about that? I hate to ask you to discuss your brethren but I was rather amazed when it came out of New Orleans referring to that. I have more than a little interest, I have a son-in-law who is studying to be a nurse practitioner.

Dr. WARD. I think there is always a concern and there has always been a concern about practice privileges, and how much education you should have to do this or that. I think the medical profession has been concerned that as they give up authority to nurses, they are losing those. Thus, it has been kind of a protective concept. In addition there has clearly been some concern that the quality of care that is given by a nurse practitioner or physicians' assistants is not to the quality as a physician.

My feeling about all of this is much simpler than that. I just see there is so much work to be done, I do not feel that there is any real validity in being concerned about the training of nurse practitioners and physician assistants. I think they can have some independent practice. I think in a general way it should be under supervision. But we have areas in our state that we have no doctors and I think that the care should be provided by nurse practitioners.

The CHAIRMAN. Of course, the midwife problem in this state——

Dr. WARD. Absolutely. Now of course, I am not the most popular one in the state when I say what I just said.

The CHAIRMAN. Did anybody else wish to comment on that? There was one other thing I wanted to mention. Gatekeeper. That is another thing that the New Orleans AMA convention came down strongly on, and that is the idea that somebody could tell you whether or not you can see this specialist. Now, the truth of the

matter is doctor choice is a very volatile subject. If you say to somebody under the President's proposal you are no longer going to be allowed to choose your own doctor, you just incurred an opponent of the plan. I must say, I can remember when Roger boasted I will never be happy until Brooke sees Dr. Madison in Boston. Well, if somebody had said no, under your plan you cannot go to Boston to Dr. Madison. You see I am affected by that, Harry, and yet I also know that sometimes that is overdone. But let us face it, this bill provides for something of a gatekeeper system where you cannot willy nilly go to the neurosurgeon because you have a headache.

Dr. WARD. But I think under this plan you could go to Dr. Madison.

The CHAIRMAN. I told you I can, but I think I am going to have to pay for it. That is the point. Is that not true?

Dr. WARD. Not necessarily. If your primary care physician, Dr. Bost who is a pediatrician, has seen your daughter and feels that this is where you should go, it is still within your option. And most options or most HMOs and some of the insurance folks can answer this better than I, but most of the HMOs will allow you to go out of the system if, in fact, there is no one within the system that can do that technology.

The CHAIRMAN. Well, now Harry, in all fairness you are going to have a difficult time, a neurosurgeon came to see me the other afternoon, he is part of a neurosurgical group here, and we talked about that very thing. It would be very difficult for an internal physician to say you have got to go to Pittsburgh or to Boston or Los Angeles or some place else, because nobody in this group of eight in this HMO can do this.

Dr. WARD. A gatekeeper concept tries to control costs by reducing some free choice.

The CHAIRMAN. And it has a lot of merit. I understand the merit system.

Dr. WARD. It has got to have it. I am just saying that you still might be able to go to a Boston doctor, it is going to be more difficult.

The CHAIRMAN. Senator Specter from Pennsylvania, has told this story and told it and told it, but it is a story of his own experience where they said no, you cannot have an MRI, your symptoms do not warrant an MRI. If you want one, you are going to have to pay for it. He said I want one and I am going to pay for it. And, they determined that he had a brain tumor and he was operated on very successfully, and he is back on the Senate floor with his hair back. But he loves to tell that story about paying for his own MRI because the system would not permit it. Charles?

Dr. FEILD. Well, one thing I think most of us would probably not go to a specialist if we have a good family doctor without consulting our family doctor anyway, and we would probably go by their recommendations. A lot of people are having a problem choosing a family doctor or family pediatrician. My neighbor had a 3-year-old and they had three different pediatric groups for each year of that child's life because he worked for a small employer, and every year the insured insurance company changed, they went with a new provider network, and every time they changed, their old doctor was not on the new list. That is the other side of the situation now

where, number one, a lot of people do what their family doctor says anyway. And number two, a number of people desperately want and cannot get a gatekeeper. Someone whose advice they can count on what they ought to do.

The CHAIRMAN. Harry?

Dr. WARD. I just have one thing. I think that Senator Specter needs a new gatekeeper.

The CHAIRMAN. Senator Specter needs what?

Dr. WARD. A new gatekeeper. His gatekeeper made a mistake.

The CHAIRMAN. That is a very good point.

Dr. WARD. You are going to be seeing Dr. Weber after lunch, but most of the gatekeepers would have identified there is something going on here and would have sent the Senator to a neurosurgeon and gotten that MRI.

The CHAIRMAN. Lee, all of these folks, my staff, are sitting here telling me I have got to go, but please, go ahead.

Mr. FRAIZER. I just wanted to mention, notwithstanding the whole concept of gatekeepers, if you looked at outcomes, basically the United States according to rural health is one of the highest cost per capita health care users. We are number one——

The CHAIRMAN. Boy are we ever.

Mr. FRAIZER. —for mortality and morbidity statistics we are about number six.

The CHAIRMAN. Something is wrong, is there not?

Mr. FRAIZER. Something is wrong. When you look at free choice, that has accomplished all of this, you begin to wonder where we are applying our priorities in that free choice alone is something that needs to be preserved in this whole system, or as Dr. Ward has indicated, perhaps in that scenario, the gatekeeper was not perhaps the best person to make that choice.

The CHAIRMAN. Gentlemen, I wish I had the rest of the day to spend with you. You are excellent witnesses and I have enjoyed this so much. I dread most of my hearings in Washington, whether it is Parks or Agriculture or Small Business. This one I looked forward to, and it has been very instructional. Thank you very much.

[Whereupon, a lunch break was taken.]

The CHAIRMAN. The fifth panel this afternoon is on the public health sector. Our first witness is Nancy Kirsch, director of Public Health Programs, Arkansas Department of Health. Charles McGrew, director of Health Facility Services and Systems, Arkansas Department of Health. Betty Gay Shuler, executive director of Mainline Health Systems in Portland. And John Jackson, D.O., associate director of Family Medicine and director of Obstetrics, Mainline Health Systems in Eudora. Welcome to all of you, and thank you very much for taking the time to be with us.

Nancy, your name is first on the list, so please commence.

STATEMENT OF NANCY KIRSCH, DIRECTOR OF PUBLIC HEALTH PROGRAMS, ARKANSAS DEPARTMENT OF HEALTH, LITTLE ROCK, AR

Ms. KIRSCH. Thank you, Senator. I am pleased to be here. Several of the things that are in my written testimony I am going to skip over——

The CHAIRMAN. All of your written statements, if you do not choose to give them, will be included in the record, and feel free to extemporize, if you would like.

Ms. KIRSCH. Thank you. An effective resolution to the crisis in health care delivery can only occur with the development of a system that promotes and enhances the health for each individual through two interrelated parts, the personal health care services and the public health system.

The public health system has a history of addressing broad-based needs; protecting citizens against preventable, communicable diseases, and environmental hazards; identifying and controlling outbreaks of communicable diseases; informing and educating consumers and providers; defining and validating new prevention and control interventions.

More recently, and particularly in southern states like Arkansas, an increasing number of dollars have been spent to support preventive primary care to the uninsured and underinsured and the underaccessed—people who do not have access to health care for other reasons.

The Department of Health in Arkansas addresses many issues which some providers of health care services do not; adolescent pregnancy, rural health needs, special needs of vulnerable populations, and assisting people to gain access to medical care. Our department has grown to a statewide network of 96 full-time local health units, 38 part-time satellite clinics, and 24 school-based clinics.

I might add that public health is broader than what is provided through local public health agencies, but I will address that in additional comments. "Public health is what we, as a society, do collectively to assure the conditions in which people can be healthy." The greatest improvements in health status have been derived from public health approaches.

The Institute of Medicine in a 1982 study found that only 10 percent of premature deaths among Americans could have been avoided through improvements in medical treatment, whereas 50 percent of premature deaths could have been avoided by changes in individual behaviors such as tobacco use, sexual behavior, eating habits, et cetera. While the focus, therefore, of health care reform has been on cost and access issues, a successful health care system must include an effective system of public health that emphasizes health promotion and disease prevention.

Public health in Arkansas has the dual challenge of assuring the provision of quality care and providing that care in many instances to underserved citizens. We provide environmental health services; encourage, purchase, or provide additional population-based services such as health promotion and education programs; maintain the capacity to respond to emergencies such as outbreaks of disease; and administer quality assurance programs such as facilities licensing and enforcement of health standards and laws.

We also provide clinical preventive services to bridge the gap between public health and the medical care system. As the number of uninsured and underinsured has grown, we have turned more of our attention and our resources to providing primary care services through local health clinics. These clinics serve disadvantaged pop-

ulations, particularly the poor, minorities, and people with complex medical conditions, who either lack money to seek care or face other obstacles to using the system such as lack of education, cultural differences, or residence in an underserved area.

As a result, we provide clinical services now to over 160,000 people annually, half of whom have no health care insurance. In FY 1993, our local Health Department served almost 50,000 child health patients, provided prenatal care for 16,000 maternity patients, served 68,000 family planning patients and gave over 400,000 doses of vaccine. In addition, we made over 1.2 million home visits. Even if these services are eventually covered by the health care reform plan, many of these people will lack access.

Since we have experience in responding to the gaps, we will continue to be critical as a player in meeting the needs of patients when services are not covered under a health care reform plan that are still needed, when persons are not covered such as people who are not citizens, when areas are without adequate providers, or services are not available from providers. Ultimately, we expect our role to change, but we have learned that personal medical services are not sufficient to improve health when individuals live in conditions of poverty and isolation.

And therefore, although more of the clinical services may be provided by other providers, enabling services such as outreach, care coordination, home visiting and health education will continue to be required from our department. We are going to have to look at developing new partnerships and new ways of working within the system to make sure that everyone is served.

Senator Bumpers, public health in Arkansas is in the business of keeping people healthy and responding to gaps in primary care. As you know, we are a critical part of that fragile infrastructure that now exists in our state, and we believe we will continue to be. Any successful health care reform effort must ensure that public health is supported, particularly during the transition, and is strengthened in the long-term.

In closing, I would like to echo Dr. Ward's plea that funding for public health be part of any entitlement that is passed for health care reform, and not left out as part of the overall program. Thank you.

[The prepared statement of Ms. Kirsch follows.]

PREPARED STATEMENT OF NANCY KIRSCH, DIRECTOR, BUREAU OF PUBLIC HEALTH PROGRAMS, ARKANSAS DEPARTMENT OF HEALTH

PUBLIC HEALTH AND HEALTH CARE REFORM

INTRODUCTION

In 1787, Thomas Jefferson wrote that, "without health there is no happiness. An attention to health, then should take the place of every other object."

That statement stands true today. And, today, health has moved to the forefront of America's agenda. We are re-examining every aspect of the health care system.

The statistics describing health system problems in the United States have become familiar, but are nonetheless compelling. The health care portion of our Nation's GNP is projected to reach 14 percent this year. In 1990, it took approximately 25 percent of American business profits. Per capita health spending in the United States is the highest in the world. Despite these expenditures, too few people are covered by basic health insurance. And, high medical expenditures have not consistently translated into improved quality of life or greater life expectancy.[1]

These problems have prompted a national health care reform movement. An effective resolution to the crisis in health care delivery will only occur with the development of a health care system which seeks to promote and enhance health for each individual through two interrelated parts: the personal health care services system (medical care) and the public health system.[1]

The role of public health in promoting and protecting our citizens' health is as old as our Nation. The public health system has a history of addressing broad-based needs:

- protecting citizens against preventable, communicable diseases, and environmental health hazards;
- identifying and controlling outbreaks of infectious diseases and community-wide patterns of chronic disease and injury;
- informing and educating consumers and providers about preventing and controlling disease and injury and the appropriate use of medical services; and
- defining and validating new prevention and control interventions.[1]

More recently, because of the increasing number of uninsured and underinsured, the public health system has provided primary preventive care to this population.

In Arkansas, this tradition of service includes the assessment of health status and needs, development of public health policy, promotion of community-based systems of preventive and primary care, enforcement of regulations for environmental health protection and assurance of quality care, and provision of quality health services. The Arkansas Department of Health (ADH) addresses many issues which most other providers of personal health care services do not—teen pregnancy, rural health needs, special needs of vulnerable populations, and assisting people in gaining access to medical care. The Department has grown to include a Statewide network of 96 local health units, 38 satellite clinics and 24 school-based clinics.

CORE PUBLIC HEALTH

The 1988 Institute of Medicine study, The Future of Public Health, described the mission of public health: "Public health is what we, as a society, do collectively to assure the conditions in which people can be healthy." Whether you assess historical advances against infectious diseases or contemporary gains against heart disease, the greatest improvements in health status have been derived from public health approaches.[6]

A 1982 study by the Institute of Medicine found that only 10 percent of premature deaths among Americans could have been avoided through improvements in access to medical treatment. Further, the report stated that 50 percent of premature deaths could have been avoided by changes in individual behaviors such as tobacco use, sexual behavior, eating habits, sedentary life style, use of alcohol and other drugs, violent and abusive behavior, and other risk taking behaviors that lead to injury. These behaviors occur within the context of a social environment. They are often paramount in communities where poverty rates are high; housing, educational services, and social support services are inadequate; and jobs are not available.[6]

The IOM report also attributed 20 percent of premature mortality to environmental factors and the final 20 percent to inherited or genetic factors.[6]

Thus, while the focus of health care reform has been primarily on cost and access issues, a successful health care system must include an effective system of public health. Improved prevention and primary care efforts will not only save lives, but valuable health care resources as well. For example:

- The lifetime cost of caring for an infant born with congenital rubella syndrome is $354,000.
- For every $1 spent on immunizations, more than $10 is saved.
- Teenage pregnancies cost the government more than $20 billion a year, yet, a $1 investment in family planning services saves more than $4 in health and welfare costs.
- It costs $50,000, on average, before a low birthweight baby can leave the hospital, but it costs only $4,800 for comprehensive prenatal and delivery care.[1]

Public health measures such as health promotion; disease prevention (including screenings, early detection, early care and treatment); epidemiologic services; and assurance of environmentally safe air, water and food supplies for all communities are essential if we are going to increase the healthy life span of all Americans and reduce health disparities at an affordable cost.

Public health services are carried out through three core functions.

Assessment

This is the regular collection, analysis and sharing of information about health conditions, environmental health, and risks and resources in a community. The Department of Health uses the assessment function to determine information regarding vital statistics; to identify trends in illness, injury, disability, and death; and to isolate the factors that may cause these events. Sanitary surveys, air and water monitoring, facility inspections, and laboratory test data must be collected, analyzed and made available for environmental health protection activities. Data on the range and quality of services, consumer complaint follow-ups, facility and professional licensures, etc. must be collected, analyzed and distributed.[4]

Policy Development

Federal, State and local public health agencies also work to develop policy in response to specific health situations. This process uses data from the assessments described previously to support and encourage better health. To be effective, the policies must be politically and organizationally feasible, respect community values, be open to private and public sectors, and effectively communicate problems and needs in order to build constituencies.[4]

A recent example of this cooperative effort is Healthy People 2000. This report was published at the Federal level after extensive consultation with State and local health agencies and community groups. It now serves as the basis for a nationwide effort to improve the health of all Americans.[4] In Arkansas, over 250 professionals, served on 19 work groups and worked over 9 months to prepare the Healthy Arkansans 2000 report. This report is a working document for the Department of Health in planning and budgeting public health priorities.

Assurance

Public health agencies must assure that necessary, high quality services are available to all. As part of this effort, public health agencies provide environmental health services; encourage, purchase, or provide additional population-based services, such as health promotion and education programs; maintain the capacity to respond to emergencies such as outbreaks of disease or spills of toxic chemicals; administer quality assurance programs such as facilities licensing, enforcement of health standards and laws; and monitor health care system performance.[4] The assurance function also includes working with communities to respond to local priority health needs such as transportation, local emergencies, service system development and other unique health issues.[3]

PERSONAL HEALTH SERVICES

Population-based prevention activities that extend beyond the boundaries of individual providers and facilities are also necessary. Clinical preventive services bridge the gap between public health and the medical care system. This includes prevention services targeted to individuals as well as early identification of disease processes. For example, lead poisoning, vaccine preventable diseases, sexually transmitted diseases, tuberculosis and infant mortality require community-wide public health approaches, including outreach, screening, linkage to care, monitoring and education.[1] Furthermore, the economic benefits of these services are well documented. (See Table 1.)

While public health services benefit everyone, they often target high risk populations and low income, disadvantaged groups. As the number of uninsured and underinsured has grown, local health departments have turned more of their attention and resources to providing "last resort" primary care services. These clinics serve disadvantaged populations, particularly the poor, minorities, and people with complex medical conditions, who either lack money to seek care or face other obstacles to using the system, such as lack of education, cultural differences, or residence in a medically underserved area.[5]

As a result, the Arkansas Department of Health provides clinical services to over 160,000 patients annually, half of whom currently have no form of health insurance. In FY 1993, Arkansas' local health departments served 48,000 child health patients, provided prenatal care for 16,000 maternity patients, served 68,000 family planning patients, performed 56,000 HIV tests with counseling, and administered over 400,000 doses of immunization vaccine. In addition, ADH made over 1.2 million home visits. Approximately one-fourth of the frail patients and one-third of the chronically ill patients were uninsured.

Even if these services are eventually covered by the health reform plan, many of these patients will still lack ready access to health services. In order to provide "universal access," health reform must address not only financial issues, but issues

such as availability of providers and geographic barriers to care.[1] In Arkansas, there are 61 primary care health professional shortage areas, 29 of which cover entire counties. Moreover, 71 of Arkansas' 75 counties are considered partially or fully medically underserved.

Public health agencies have experience in meeting the unique needs of low-income and hard-to-reach populations. Thus, while many of the personal health care services now provided by the Department of Health will be reimbursed by the new system, public health clinics will continue to be critical in meeting the needs of patients when

- services are not covered by the health care reform plan,
- persons are not covered (such as non-citizen residents),
- areas are without adequate local health care providers, and
- services are not available from local health care providers.[3]

The array of personal health services provided in a particular clinic may be increased, decreased, or changed based upon community needs and as the health care plan is developed and implemented. Public health has learned experientially that personal medical services are not sufficient to improve health when individuals live in conditions of poverty and isolation.[2] Therefore, although more of the clinical preventive services may be provided by other health care providers, enabling services such as outreach, care coordination, home visiting and health education will continue to be required of the Department of Health.

CONCLUSION

The goal of health care reform is to achieve a longer and healthier life for all Americans, regardless of social or economic status. Although access to personal health care services is critical, these services alone will not assure that Americans are healthy. In addition to a reformed medical care system, core public health functions and enabling services for vulnerable populations must be enhanced. Finally, Arkansas, and all States, must be given the flexibility to use our resources most appropriately and the time to ensure an orderly transition.

Table 1.
Economic Burden of Preventable Conditions

Condition	Overall Magnitude	Avoidable Intervention[1]	Cost per Patient[2]
Heart disease	7 million with coronary artery disease 490,000 deaths/yr 265,000 bypass procedures/yr 298,000 angioplasties/yr	Coronary bypass surgery Angioplasty	$30,000 $15,000
Cancer	1,130,000 new cases/yr 520,000 deaths/yr	Lung cancer treatment Cervical cancer treatment	$23,000 $15,000
Stroke	600,000 strokes/yr 145,000 deaths/yr	Hemiplegia treatment and rehabilitation	$22,000
Injuries	2.3 million hospitalizations/yr 142,500 deaths/yr 177,000 persons with spinal cord injuries in the U.S.	Quadriplegia treatment and rehabilitation Hip fracture treatment and rehabilitation Severe head injury treatment and rehabilitation	$570,000 (lifetime) $40,000 $310,000 (lifetime)
HIV infection	1-1.5 million infected 118,000 AIDS cases (as of January, 1990)	AIDS treatment	$100,000 (lifetime)
Low birth weight baby	260,000 LBWB born/yr 23,000 deaths/yr	Neonatal intensive care for LBWB	$10,000
Inadequate immunization	Lacking basic immunization series: 20-30%, aged 2 and younger 3%, aged 6 and older Hepatitis B	Congenital rubella syndrome treatment Acute hepatitis B treatment (hospitalized)	$354,000 (lifetime) $6,386
Lead toxicity	200,000 children under age 6 with blood lead levels above 25 mg/dL	Medical cost of treatment	$13,000
Dental caries	21.69 million children aged 5-17 have one or more dental caries	Caries restoration	$39

[1] Examples (other interventions may apply)
[2]Representative first-year costs, except as noted. Not indicated are non-medical costs, such as lost productivity to society.
Source: DHHS

SOURCES

[1] "ASTHO Statement on Health Care Reform," Association of State and Territorial Health Officers, May 20, 1993.
[2] "Health Care Reform and Maternal and Child Health in the South," Special Delivery, Southern Regional Project on Infant Mortality, Fall, 1993.
[3] "The New Mexico Department of Health and National Health Care Reform," State of New Mexico Department of Health, 1993.
[4] "APHA's Vision: Public Health and a Reformed Health Care System," The Nation's Health, July, 1993.
[5] "Delivering Services to Poor Women and Children: Public Health Safety Net Providers under Health Reform," Issue Brief, National Health Policy Forum, George Washington University, October 15, 1993.
[6] "Public Health in the Era of Health Care Reform," Philip R. Lee, M.D., Assistant Secretary for Health, U.S. Department of Health and Human Services, 1993.

The CHAIRMAN. Thank you very much, Nancy. Charles?

STATEMENT OF CHARLES McGREW, DIRECTOR OF HEALTH FACILITY SERVICES AND SYSTEMS, ARKANSAS DEPARTMENT OF HEALTH, LITTLE ROCK, AR

Mr. McGREW. Senator Bumpers, since you have had a long list of excellent folks who have testified on different parts of the system, health care reform in the State, and since you will have other people this afternoon that will cover a number of issues, I am going to try to focus briefly on three areas. One is manpower, the second, as Nancy has mentioned, is the infrastructure issue, the fragile infrastructure in Arkansas in many rural communities, and then the community's role and responsibility.

As far as manpower is concerned, nationally, between 1970 and 1992, the total number of physicians in the country increased from roughly a quarter million to more than half a million, a 104 percent increase. The number of family practice physicians in rural or non-metropolitan counties increased 3 percent, the same time that the total numbers in the country increased 104 percent.

As a matter of fact, in rural areas, what we saw was a decrease in the percentage of physicians that were in those rural areas, a decrease from about 15 percent to 12 percent. In Arkansas, that certainly is consistent with what we have seen, we estimate that we have right now a shortage of about 300 family practice physicians in the State in the current supply.

The CHAIRMAN. 300?

Mr. McGREW. A shortage of 300 currently, right.

The CHAIRMAN. Okay.

Mr. McGREW. We also know that the number of those finishing their residencies and going into practice in rural communities is not sufficient to keep up with the number that are retiring from rural communities right now. So, not only do we have a 300 deficit of family physicians in the State, that deficit continues to grow. We are going in the wrong direction.

We also know that there is a real opportunity right now with certified rural health clinics, with community health centers, with physicians in rural areas in their private practice to use midlevel practitioners, nurse practitioners, nurse midwives, certified nurse midwives, and physician's assistants. However, those people are not available in the State right now.

We have an excellent program at UAMS to train family nurse practitioners, but the numbers are small, the program is relatively

new. We currently have 37 certified rural health clinics in the State.

The CHAIRMAN. How many?

Mr. MCGREW. 37. That number has increased dramatically in the last 3 years. The ones who are now trying to be certified because they must, by law, have to use a midlevel practitioner half of the time they are open are having problems with the certification process. Community health centers are in desperate need of nurse practitioners and midlevel practitioners.

The CHAIRMAN. Is that a State or Federal regulation, Charles?

Mr. MCGREW. The requirement——

The CHAIRMAN. The requirement that 50 percent of the time they have to have a family practitioner.

Mr. MCGREW. That is a Federal regulation, Public Law 95-210. But we know that a part of our solution in this state, in the short-term, to manpower is being able to use that combination of family physician and family nurse practitioner in the right way, simply is not available, because we have neither of those.

It is my opinion that what is going to happen with health care reform and what is already happening with network formation is going to pull more family physicians out of rural areas, and we will actually see the situation get worse in the State.

We also know that around the country what is happening right now is that nurse practitioners who are skilled and even those who are fresh out of school are being recruited in the urban networks, because it is a cost-efficient way to increase the amount of primary care that can be provided.

We know that physicians in small group practices around the State are in desperate need of help with recruitment, with practice management, with being linked to other providers in the community, and we do not have ways of doing that very efficiently.

I guess my plea would be that as we move forward with health care reform, even though these issues regarding manpower are talked about a lot, and they are addressed in different ways, I do not think that any combination that I have seen at the State level and what has been proposed at the Federal level really addresses anywhere close to an adequate solution to the manpower and the reality of what is going to happen.

I think that with family physicians, we have a 15- to 20-year transition period before we are going to start to get where we need to be if we do things right with nurse practitioners and certified midwives. Again, the supply is not there, and it is a wonderful option for urban networks. I am not being critical of those folks who are trying to recruit that manpower, but it means that those of us who are concerned particularly about rural areas see a pretty bleak future as far as manpower is concerned.

The infrastructure issue and the issue of—in the interest of time, I am going to skip over a little bit. Betty will get into some of that, talking about, again, how critically important it is to look at the providers that are out there right now in the communities.

The last issue, I would like to submit to you is a brief paper that was presented last week in a conference that we had in Iowa as a followup to the Little Rock conference in March on rural health care reform. The paper takes research that has been done by Dr.

Bruce Ammondson in Washington State over a period of years working with rural hospitals and rural communities, and really outlines the specific kinds of technical assistance that community-based health care systems desperately need in order to survive. And the focus on making sure that the community really maintains some control and responsibility for their health care system, it gives a real opportunity for partnership between the large providers of care who can put resources out there, but leaves the community in control of the health care system at the community level, which I think right now, again, is really not addressed.

We have got to somehow make sure that the community has a meaningful role in control of the system. And I would suspect that Betty probably will also talk some about the community role. Thank you very much.

The CHAIRMAN. Charles, Betty, how many clinics do you all have? How many different locations does Mainline have?

Ms. SHULER. We have four, and one dental clinic.

The CHAIRMAN. Are you counting that as five of the 37?

Mr. MCGREW. We have two different kinds of clinics we are talking about. Betty will talk about community health centers and the number of prototypes that they have in the State, and those are funded by a combination of a Federal grant, earned monies, reimbursement from different sources. Certified rural health clinics can be either freestanding, which means that they are owned and run by a physician, or they can be provider-based, which means that they are part of a hospital, normally a rural hospital system. Those clinics have to use a midlevel practitioner 50 percent of the time that they are open, and they have to be in an underserved rural area.

The CHAIRMAN. How many of those do we have?

Mr. MCGREW. There are 37 of those.

The CHAIRMAN. That is the 37?

Mr. MCGREW. Right, that is the 37. Betty will be addressing the number of community health centers and locations.

The CHAIRMAN. Would you send me a list of those 37?

Mr. MCGREW. Yes.

The CHAIRMAN. And maybe a little bit of information, if you have it, about how many visitations last year and so on?

Mr. MCGREW. Yes.

The CHAIRMAN. That would be very helpful to me.

Mr. MCGREW. Thank you.

The CHAIRMAN. Okay, Betty.

STATEMENT OF BETTY GAY SHULER, EXECUTIVE DIRECTOR OF MAINLINE HEALTH SYSTEMS IN PORTLAND, AR

Ms. SHULER. I will just echo what Charles has already said. Where there are 37 rural health clinics, we have 30 community health centers in Arkansas right now.

The CHAIRMAN. I would like the same information on them.

Ms. SHULER. Okay. I just happen to have it all right here. I will leave it with you today.

The CHAIRMAN. Okay.

[The information referred to follows:]

MAINLINE HEALTH SYSTEMS, INC.,
604 SOUTH PECAN STREET, DERMOTT, AR 71638,
December 9, 1993.

HEALTH REFORM CONCERNS OF COMMUNITY HEALTH CENTERS IN GENERAL

MAINLINE HEALTH SYSTEMS, INC.—SPECIFICALLY

The concerns we have in our extremely rural area of southeast Arkansas are many. Health reform as it is written today will not benefit our people a great deal. Employers—mostly farmers—cannot pay their own health insurance premiums, much less those of their workers. The cost as proposed at this time:

$1,800 average annual premium for individuals, $1,500 out-of-pocket cap;
$4,200 average annual premium for families, $3,000 out-of-pocket cap.

Eighty percent of this premium for families would be impossible for the low income farming population of the area—as would the 20 percent required of employee. These are the "working poor" . . . struggling to survive.

Any idea of solution for our specific problem-low income farmers?

The paramount problem facing rural Arkansans is health care access. Our CHC in Eudora—a new facility with space for two doctors and one N.P.—cannot attract another doctor. Even with $100,000 base salary plus $30 loan repayment and incentives, no one wants to come to the Delta. Could there be some additional incentive—tax breaks, added payments, or salary supplements by the State or Federal government to assist in the alleviation of this problem?

Medicine and drug costs are astronomical and a great problem. The older people (65 or older) on regular medication for heart problems, hypertension, arthritis . . . their monthly bill can go as high as $600. They cannot pay their bills and buy medicine, so they skip the medicine or take lowered doses to "make it last longer". The end result is a major heart attack or stroke, resulting in much greater cost—both in suffering and in dollars.

Malpractice is a mounting problem in our area, also. TV ads, billboards (one was placed not 2 miles from our local hospital) stating that "help is available . . . not one dime will it cost you!" make the situation so easy . . . an 800 number to call for house calls! We have a situation at present where the patient (an OB, who no one wants to care for anymore) came in, was delivered by our doctor, and returned to Texas. After 3 or 4 years, the family sued and the insurance company settled out of court. His malpractice insurance was promptly canceled and the only coverage available was from a high risk company . . . priced at $87,000. Of course, this was beyond a CHC budget, so after a few months, he had to drop OB practice, leaving Mainline with one doctor . . . and in 1992 we had 278 women on our prenatal care rosters. These are 98 percent medicaid patients, mostly high risk—teens, etc., with nowhere else to go. There must be some cap or some type of regulation on these malpractice cases. Even if they don't win, we still have the cost and harassment going on for months and even years. This usually results in the doctors leaving for another area where the lawsuits are not so prevalent.

Transportation is not mentioned in the new health reform; this, too, is a major problem in rural areas with no public transport.

The "gatekeeper" concept will place additional hardship on rural doctors . . . there are no answering services to grant referrals at 12 o'clock midnight . . . in CHCs we have rotating physicians in our clinics; this, too, will require a referral. The paperwork involved, and the probability of the CHCs having to see all patients will increase our load and provide no reimbursement without referrals. The CHCs feel this will be a great disadvantage to them.

In brief, our greatest problem is recruitment and retention of providers. With an ever greater influx of patients—uninsured and unemployed—the CHCs face a grave situation. The Arkansas CHCs saw over 100,000 patients visits in 1992; Mainline alone (4 clinics) saw over 34,000—with additional off-site screens, both dental and medical. The CHCs form the life-saving health care for rural Arkansas and we need help from health reform, not added burdens for already overworked staff.

The problem of referrals to UAMs is great; sometimes our patients (indigents or Medicaid) must wait 2 months for an appointment. We realize the load they face, also, but our patients will not be accepted elsewhere and we are in a very difficult position.

Ms. SHULER. In 1992, we had over a hundred thousand patient visits in the community health centers in Arkansas. We opened up two new ones last year—well, we received grants for them this

year, one at Marshall and one at Corning, plus a new Migrant Center at Hope that will serve thousands of people coming through there. We never realized the need for the migrants that there is, but that is being worked on right now. The center in Marshall is starting up, and they hope to be open by the 1st of January, and the one in Corning is hoping to open by the 1st of January.

Next year, in 1994, we are going to propose two more clinics, which may or may not be funded, according to the way the wind blows and the way the money is. Right now, we are funded by 330 funds, by program generated income, and I can only speak for what Mainline receives, the money we receive from the Federal source barely meets our personnel costs. We have to generate the other.

The CHAIRMAN. Barely meets your what?

Ms. SHULER. Our personnel costs, our payroll. So, we have to generate the other. Right now, we are generating about 54 percent of what our program spends, and we have a little over a $2 million budget, but we have to generate this money ourselves, they do not just give it to us. The problem that Charles mentioned about the shortage of physicians and other providers in the rural communities is the paramount problem.

Right now, we have a brand new facility in Eudora, it is over 5,000 square feet, we have room for two doctors and a nurse practitioner, also. The community was right in there with us, they built us a nice road so we would have access, we now have a paved road. We were there in a sea of mud. But everyone in the area wants this clinic there, they need two doctors. Eudora itself is a community of 3,700 people with a large outlying community. Dr. Jackson here is the only doctor in town.

The CHAIRMAN. You are the only physician in Eudora——

Dr. JACKSON. Yes, I sure am.

The CHAIRMAN.—a city of 3,700 people?

Dr. JACKSON. Yes, sir.

Ms. SHULER. He also is the only physician in our group now who can deliver babies. I will tell the rest of that story in a little bit. But by the time he has to go to Lake Village to the hospital, which is 12 to 15 miles away, and deliver a baby and come back, here are all of these people sitting there waiting to see the doctor. Last year, we had over 10,000 visits in Eudora, the year before that, we had 10,000 visits and, needless to say, we cannot deliver the quality of care we need with one physician who is also trying to deliver all of these babies.

Chicot County is one of the poorest counties in the State, 54 percent of the total population lives below the poverty line, and female head of households is 80 percent.

The CHAIRMAN. 54 percent of Chicot County is below the poverty line?

Ms. SHULER. Yes. And 80 percent of the households with a female head are under the poverty line. This constitutes a large segment of the population of Chicot County. It is predominantly black, and as I said, we have a very bad economy. Right now, the farming community is in the worse shape it has been in during the last 10 years.

I hated to hear this, because my son went back into farming this year. We had the worse crop in Ashley and Chicot County that we

have had in 10 years. So, it will be a total disaster there, more farmers will go out of business, more people will be uninsured, more people will be unemployed, and community health centers are going to have to see more people with not enough doctors, not enough money, not enough nurses.

We have one nurse practitioner who is really a godsend. She works in all four clinics as she is needed. We have one that we share with the Health Department. They let us borrow her one day a week, and she is a big help. We do work with the Health Department in every aspect of health care. Immunizations in some places where the Health Department was without a nurse, they sent them over to us and we did their immunizations.

Well, we worked closely with them on the immunizations and on the school-based clinics, on the teenage pregnancy problem, which again is a big problem in Chicot County.

We feel like we have made a difference there. The 5 year average from 1981 to 1986 was 21.6 percent, which is worse than a lot of third world countries. It is down now to 11 percent, which is wonderful for Chicot County. It is still bad, but that is good for us. The things that we need to address down there, I am going to touch on briefly, because all of these are in my paper.

The employers in our area are mostly farmers. These farmers cannot possibly afford the expense of insuring all of these people for health care. Right now, the last figures they gave us was $1,800, an average annual premium for individuals with a $1,500 out-of-pocket cap, $4,200 for a family with a $3,000 out-of-pocket cap. 80 percent of this premium would be impossible for the farmers to pay. The workers certainly could not pay the other 20 percent, because most of them are working for minimum wage. They are the "working poor" that we hear so much about.

One of the other big problems we have is medicine and drug costs. If a person is 65 or over, and they have the problems which are very dominant in our counties, diabetes, arthritis, hypertension, and heart disease, their medicine could run well over $600 a month, and they cannot even pay their utility bills. So, they have to let the medicine go or they take it in such small doses to make it last that it really does not work. This usually results in a stroke or a major heart attack, which is a much greater cost than the drugs would have been.

Malpractice, I am not going to say much, I will let Dr. Jackson talk about this. We had a terrible experience with malpractice. We did have two doctors delivering babies, but one of these had a suit filed against him. The woman walked into the hospital, he delivered the baby, and she went back to Texas. We did not get a penny out of it, of course, and 3 or 4 years later, she sues us. The company decides they will just settle out of court, so, immediately, our doctor's insurance was canceled.

If you have something settled against you, well, you just might as well forget getting any malpractice for any decent cost. His cost went from $3,500 to $87,000. And needless to say——

The CHAIRMAN. When did this all happen, Betty?

Ms. SHULER. This happened last year.

The CHAIRMAN. $3,500 to what?

Ms. SHULER. To $87,000. And this was the only company in the United States that would even——

The CHAIRMAN. That would even take his malpractice insurance?

Ms. SHULER. Well, we paid it for a couple of months, and we had to quit. In 1992, we had 278 on our perinatal roster with two doctors working. Now, we have over 200 with only one doctor working to deliver these babies and that speaks for itself.

Something must be done about malpractice, particularly in areas like ours, where we have so many high risk patients. Everybody that walks through the door in our area, just about, is a high risk patient, particularly the pregnant girls, with the teenagers and the predominantly black population and lack of early prenatal care.

Transportation is something that has not been mentioned much in health care reform, and you all know well what the transportation is down in our area. There is no public transportation. We have our two vans that run constantly. They go to Pine Bluff, Little Rock, Greenville, and in between, and we do not have enough money to buy the tires. Just every little thing we have to squeeze out the money, because we are seeing too many people.

The CHAIRMAN. Betty, when people walk into that clinic, do they pay anything?

Ms. SHULER. They do pay. The least amount that people pay, if they are on the lowest income, is $5. Of course, we will see them if they do not have the money. But I am real happy to see that most of our people will pay the $5. We do make them try to pay, because we feel like this preserves their dignity.

The CHAIRMAN. And you get the Medicaid reimbursement on them?

Ms. SHULER. Yes, we get Medicaid. We are under FQHC, which is the Federally Qualified Health Center designation, which gives us cost-based reimbursement.

The CHAIRMAN. And Medicare?

Ms. SHULER. Yes and Medicare, it is also FQHC, now. And these two things have been a life-saver for us, we would have never made it, we would have had to discontinue some services or turn people away, which is the situation we are just about to face right now.

The CHAIRMAN. Is Dr. Jackson on a straight salary?

Ms. SHULER. He is on a straight salary plus an incentive for the number of patients that he sees in the hospital, and plus the number of babies he delivers. We feel like this is only fair, and we pay a good salary, but nobody wants to come to the Delta. By the time we give our base salary plus incentive, plus loan repayment if they need it, it is basically a $150,000 package right there. But they come and take one look and say, "You know, we believe we will go on back to Little Rock." People do not want to come to the Delta.

Our schools are not good, our transportation is terrible, our cultural advantages are practically nonexistent, and only those of us who have lived in the Delta all our lives want to be there. Except now, Dr. Jackson came down to us from Michigan and decided to stay. But you have to be a special kind of person to want to work in a community health center. It is just almost missionary work, because the hours you have to spend and the work you have to do and the type of clientele you deal with are, a lot of them, equal or less than the health care in third world countries.

I think I have talked long enough.

The CHAIRMAN. Well, Betty, that is really staggering information.

Ms. SHULER. It is, and, you know, that is just touching the tip of the iceberg.

The CHAIRMAN. I know.

Ms. SHULER. I could quote a million statistics.

The CHAIRMAN. I am going to come down and see you soon.

Ms. SHULER. Good.

The CHAIRMAN. Okay.

Ms. SHULER. Come on down. We have a nice clinic in Wilmot and it is going well right now. In Portland, we are in an old building that badly needs painting.

The CHAIRMAN. Yes. I have been out to the clinic in Portland.

Ms. SHULER. You have visited the one there, but we really want you to see Endora.

[The prepared statement of Ms. Shuler follows:]

MAINLINE HEALTH SYSTEMS, INC.,
604 SOUTH PECAN STREET, DERMOTT, ARKANSAS 71638,
December 9, 1993.

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In brief, our greatest problem is recruitment and retention of providers. With an ever greater influx of patients—uninsured and unemployed—the CHCs face a grave situation. The Arkansas CHCs saw over 100,000 patients visits in 1992; Mainline alone (4 clinics) saw over 34,000—with additional off-site screens, both dental and medical. The CHCs form the life-saving health care for rural Arkansas and we need help from health reform, not added burdens for already overworked staff.

The problem of referrals to UAMs is great; sometimes our patients (indigents or Medicaid) must wait 2 months for an appointment. We realize the load they face, also, but our patients will not be accepted elsewhere and we are in a very difficult position.

The CHAIRMAN. Dr. Jackson, I am anxious to hear from you.

STATEMENT OF DR. JOHN JACKSON, ASSOCIATE DIRECTOR OF FAMILY MEDICINE AND DIRECTOR OF OBSTETRICS, MAINLINE HEALTH SYSTEMS IN EUDORA, AR

Dr. JACKSON. Thank you.

Ms. SHULER. He can tell you even worse stories.

The CHAIRMAN. Where did you go to medical school?

Dr. JACKSON. I went to school at Michigan State.

I am a board certified family practitioner. I am employed by Mainline Health Systems. One of the reasons why I sound so low and incredibly tired is that last night I was called to come at 7 p.m. just as I was getting ready to leave for Little Rock. One of my female patients, who is a 24-year-old, is employed, has one child at home, and is also married, called me at my home at 7 p.m., because she was bleeding and cramping.

So, I canceled my plans to leave for Little Rock last night, and I essentially went into the hospital to treat her. She has no insurance, her husband works as a tugboat employee, and he also has no insurance, all right? And I am incredibly pleased to say that everything turned out okay. However, I was not home until midnight last night.

This sort of care is incredibly common to southeast Arkansas, that our county has seven very, very good physicians that every single one of us take pride in our work and also spend a lot of time with all of our patients.

As Betty said, I am the only doctor in our town in Eudora. On my Thursday afternoons off, I also do volunteer work in a town of a thousand people in Arkansas City which, unfortunately, starting as of January 1, I cannot go to anymore because I have found out that my malpractice insurance will not cover the sort of volunteer work that I do, because that there is no official record of me seeing anybody in Arkansas City.

One of the things that I would like to touch upon is that within our area, that even if you provide health insurance for every single person there, there is still a very severe shortage of family doctors. Commonly, my patients wait anywhere from 2 to 4 hours to see me, because I am the only doctor in town. I know numerous times I am in the office until 7 p.m. or 8 p.m. at night seeing patients. I

even do house calls, which I do not charge anything for, because numerous of my patients have no financial means anyway.

However, our area needs more family doctors. We also need to do something about this malpractice situation, because it is making it very, very hard for us to recruit doctors if they know the odds of them being sued in southeast Arkansas are the same as them being sued in Little Rock, Arkansas. The feeling is, "Well, you know, why should I come to southeast Arkansas?"

Our area needs basically everything, but I actually feel that there are things that can be done to increase the number of family doctors in the area. Number one, somehow, the Government has to force training programs to produce more family doctors. I do not need any more surgeons or cardiologists or internists. What I essentially need are more family doctors.

Second, something also has to be done to increase nurse practitioners. We need to somehow standardize the nurse practitioner program so I know that somebody has either had 1 year, 2 years, or 6 months of care.

Third, we also need to start training people from rural areas and encouraging them to go back to rural areas. One of the things that I have found in our area, outside of myself, is that everybody who is in practice in southeast Arkansas is essentially from southeast Arkansas. Therefore, common sense would essentially tell me that perhaps we need to look at medical school applicants from southeast Arkansas.

In closing, as I said, any sort of health insurance, or any sort of health care reform has to do something about increasing the number of family doctors. Now, in our area I basically do everything, I do OB, pediatrics, geriatrics, cardiology, et cetera, et cetera, et cetera. However, for myself, there is not enough time in the day for me to do all of the work that essentially needs to be done in our community. Thank you.

The CHAIRMAN. Dr. Jackson, do you practice in the other clinics, for example, in Portland?

Ms. SHULER. Yes.

Dr. JACKSON. On Tuesday afternoons, I am in Portland, where I also do obstetrics and pediatrics. And Monday through Friday, I am in my office in Eudora. I also have a very, very active hospital practice in Lake Village, I average anywhere from 3 to 10 patients a day in our hospital.

The CHAIRMAN. Is this hospital in Eudora?

Dr. JACKSON. No, our hospital is in Lake Village, it is a 47 or 50 bed hospital.

The CHAIRMAN. How far is it from Lake Village to Eudora?

Dr. JACKSON. 19 to 20 miles. One other thing about transportation, the first 2 years I was in southeast Arkansas, numerous times I would put patients in my own personal car, and either drive them to Lake Village Hospital, or even over to Greenville, which is an hour away. Recently, over the last 5 or 6 months, I have been forced to stop doing that out of fear of something happening and of being sued.

The CHAIRMAN. How long have you been down there?

Dr. JACKSON. Three and a half years, now.

The CHAIRMAN. Did you come there under the National Health Service or——

Dr. JACKSON. No, no.

The CHAIRMAN. You just came on your own?

Dr. JACKSON. Yes, sir.

Ms. SHULER. He liked our looks.

The CHAIRMAN. Why did you do that, what prompted you to do that?

Dr. JACKSON. Essentially, all my life I have always wanted to practice in a nice, small town in the south, and Eudora was essentially looking for a doctor. Financially, and this is still true of today, I am—financially, I can make twice the salary that I am making now elsewhere, because outside of Eudora, there are thousands of small towns, many of them with lots of money, that are actively looking for family doctors who practice OB.

One of the bad things about my medical training is that the majority of my medical training was essentially geared towards taking care of patients within the city. Very, very little of my medical training was essentially geared towards taking care of people in rural areas. I feel that that is something which definitely has to be addressed.

My colleagues in Chicago practice medicine drastically differently than the way that I am practicing medicine, essentially because they have so much more support staff than I have.

The CHAIRMAN. Are you suffering burnout?

Dr. JACKSON. At times, I am.

The CHAIRMAN. How many people do you see on an ordinary day?

Dr. JACKSON. Anywhere from 30 to 50.

The CHAIRMAN. How many babies did you deliver this year, so far?

Dr. JACKSON. So far, I think I am up to 125.

The CHAIRMAN. 125?

Dr. JACKSON. Yes, sir. I average anywhere from 5 to 20 births a month, and also in the office, I do the majority of the prenatal care and also all of the screenings. One of the things I think that I am really, really hoping that health care reform takes care of is that. Easily, about 60 to 70 percent of my time, time in obstetrics, is essentially put into filling out forms.

One of the things that I also do is that I am essentially being forced to practice defensive medicine, just in case something happens, I know that their employer is going to ask for this certain task, et cetera. I feel that we essentially have to do something about that.

In our area of Eudora, health care in Eudora is essentially Mainline Health Systems and me, and if something were to happen to me, or if I was to leave, or if anything, if I am driving home and God forbid I am in an accident, my town would have nobody to take care of its health care needs.

The CHAIRMAN. Well, I tell you, that is a gripping, compelling story. I do not really have any questions for any of you, simply because I am so totally committed to public health, to the public health sector, the community health facilities and community-based public health clinics, but this has caused me today to renew

my interest in it. And you heard Dr. Ward this morning testifying about how he would recommend setting aside at least half of one percent for this purpose.

I am sure it might even be better for us than that, because as I said, I think that it has probably got the best return for the money spent by far on any part of the health care delivery system in the country.

Dr. Jackson, I tell you, I admire you so much, I cannot express it in words. I understand from a humanitarian standpoint, but just from your own personal interest, you have to be a very rare creature to do what you are doing. And there are going to be more angels dancing around and putting stars in your crown than you ever will be able to accommodate.

Ms. SHULER. One thing Dr. Jackson did not mention is the fact that he is also teaching a biology lab over at Eudora High School, they did not have a biology lab teacher. So, he goes over there on Friday morning and teaches the biology lab. And they did not have any equipment, so we had to get out and find some money for that.

Of course, we did not have any money, so we badgered people and drug companies, and all such things, until we got some microscopes, and he did have some fish in the aquarium, but the shark ate them. But this is something that he did on his own because he wants to help the community and he saw the plight of the educational system in Eudora.

The CHAIRMAN. You know something, Dr. Jackson, I do not know of anything that causes a greater reaction from me than for people to suggest to me, without actually saying it, that a child born in Pleasant Valley and a child born in Eudora have the same opportunities. I know what the Eudora situation is, I know the poverty level, I know what the schools are like, I know the opportunities that exist for people from affluent families and the opportunities that exist for people from poor families.

It is a poor county, it is a poor city. The opportunities simply do not exist there. And there will be a few who make it, there will be a few stars, you know who they are when you teach that class, you can pick the sparklers out. When I speak to 50 kids that come to Washington, and I open it up for question and answer, I can tell you precisely from the questions who the sparklers are in that group, who is going to make it, and who is not.

But I do not know, I am just such an idealist, I think of what a human waste of all of that talent that could be salvaged. Even in southeast Washington, what chance do they have, what chance to the kids in College Station here have? Well, they have a chance, but that is about all that you can call it. So, that is the reason I say that the thing that is wrong with Government is not just politicians, it is because those politicians do not have their priorities straight.

As I said in my luncheon speech today, nobody asks "Where are you going to get the money," when we are building 50,000 warheads to destroy the planet. But when you start talking about health care, "Where are you going to get the money?"

That is what is wrong with the priorities in this country. That is the reason oftentimes we despair and we wonder if there are any people left who care. I am happy to know that there is at least one

down in Eudora and, of course, you, too, Betty, I know you are working.

Ms. SHULER. I am not there much.

The CHAIRMAN. Well, I thank you all very much for being here today. And I will do everything I can to make certain not only that you are protected, but try to find something you are satisfied with.

Dr. JACKSON. Thank you.

The CHAIRMAN. Our sixth panel this afternoon consists of providers. Dr. Mary Louise Corbitt, North Little Rock; Dr. Glen Baker, president of the Arkansas Medical Society; Dr. Jim Weber, president-elect of the American Academy of Family Physicians from Jacksonville. We welcome all of you. Dr. Corbitt, your name is first, so please proceed.

STATEMENT OF DR. MARY LOUISE CORBITT, NEUROLOGIST, AND COFOUNDER OF THE NEUROLOGY GROUP AND THE ARKANSAS HEADACHE CLINIC

Dr. CORBITT. Thank you. Senator Bumpers and staff, I am pleased to have this opportunity to be here today. I am Dr. Mary Louise Corbitt, a board certified neurologist and cofounder of the Neurology Group and the Arkansas Headache Clinic. As a lifelong resident of Arkansas, I graduated from Hendrix College and the University of Arkansas School of Medicine where I completed my neurology residency in 1976. I served on the clinical faculty as Assistant Professor of Neurology until I entered private practice.

My practice has been devoted to general neurology until 1987 when I cofounded the Arkansas Headache Clinic. Since that time, I have devoted my practice to the evaluation and treatment of patients from Arkansas and surrounding states who suffer from very debilitating head pain and related disorders.

I come before you today on behalf of the neurologists of our great State and on behalf of our patients who suffer from a myriad of very complicated and often debilitating medical illnesses such as headache, epilepsy, multiple sclerosis, Parkinson's disease and Alzheimer's disease. These neurology illnesses, as well as other chronic medical illnesses such as diabetes and heart disease, require special consideration in any health care plan.

Early diagnosis and effective medical management are critical to achieve cost containment and meaningful health care benefits. Any comprehensive health care plan must address the treatment realities of the patients with these chronic illnesses.

In addition to my oral testimony, I would like to submit for your consideration the "Principal Care Statement" issued September 1993 by the American Academy of Neurology. The concept of principal care refers to the ongoing care of a patient provided by a specialist for the patient's principal illness. The Academy of Neurology strongly encourages those entrusted with the crafting of our future health care plan to include this important concept of principal care within the plan. Neurologists, as the principal care providers for neurological illnesses, are the only providers who have the necessary training, knowledge, and experience to provide cost efficient diagnostic evaluations, treatment and management for these disorders.

I would like to devote the remainder of my remarks to headaches, which is the most frequent occurring and most frequently misdiagnosed and mistreated neurological disorder. Over 40 million patients suffer from headache in the United States. A headache is invisible, yet it severely impacts the quality of life and everyday function of anyone who regularly lives with this chronic disorder. Those who suffer from headache are much less likely to be referred to a neurology or headache specialist than is a patient suffering from epilepsy, multiple sclerosis, Parkinson's disease or Alzheimer's disease.

Primary prevention, which includes such worthwhile practices as immunization and early prenatal care, is well recognized as being cost effective. Secondary prevention, which is the aggressive management and treatment of an existing illness is not as well recognized as being cost effective. The prevention of costly complications and deterioration in function is of critical importance to any quality health care plan.

In a specialty the treatment of chronic headaches, secondary prevention includes the prevention of a host of common problems seen in the headache patient. These include the development of unnecessary drug dependency, needless surgery, redundant testing, unnecessary hospitalization, disability, depression, and even suicide. All of these potential problems encountered in this chronic illness may be reduced or totally prevented by effective treatment, and when necessary, utilization of coordinated systems of outpatient and inpatient care. Treating these patients appropriately and early after onset of chronic headache has a potential to save millions of dollars in health care costs, as well as loss of productivity in the workplace. It is also the only way to efficiently provide and restore long-term quality of life to a chronic headache sufferer.

In the Arkansas Headache Clinic, we see patients with severe pain who desperately seek and require proper diagnosis and management. These patients desire prevention and want to free themselves from the shackles of inappropriate and costly use of narcotics and temporary solutions which frequently make their problem even more complex, and in the long-term more costly to treat. We see patients who have bounced from emergency room to walk-in clinics, from doctor to doctor without any real improvement in their long-term condition. Many, if not most, of these patients frequently have had unlimited and uncoordinated services and procedures performed in search of pain relief.

Over 70 percent of our new patients overuse over-the-counter pain relievers, prescription narcotic pain relievers or both. Many have had their sinuses opened, their teeth extracted, jaw joints adjusted, eyeglasses fitted, skin tested for allergies and even neck manipulations and more—all in the name of headache treatment and cure. These patients are generally not referred to the specialist until after thousands of dollars of well-intentioned but failed services have been provided. As a result of this delay in appropriate treatment, this complex illness has become even more difficult and costly to treat.

To further illustrate the personal impact and magnitude of chronic headache and the necessity for early principal care provider referral, I also include for your review the attached brief case

histories from our clinic, a very poignant letter from a patient of mine who gave her permission to submit her letter to this testimony and a few dramatic facts concerning headache.

In closing, I would like you to join me for a moment to returning to a time when the moral obligations of the physician were his or her guiding force and not financial disincentives or external pressures. The year was 1951 and the patient was a snaggled-toothed little girl, the only child of a very hard working couple of modest means. The child developed a high fever, the family physician referred her to a pediatrician, and the pediatrician referred the little girl to a cardiologist. The diagnosis of rheumatic fever was made.

The decisions of the family physician and the pediatrician for their respective referrals were not affected or controlled by any financial disincentive to refer. The "gatekeeper" of medicine was not a board of directors or a managed care company issuing practice management guidelines. The physician's decision to refer came totally from within, based on his medical knowledge, his concern for his patient and his moral obligation to provide that patient with the best medical care available.

The little girl recovered completely and as a result of this experience, grew up with an admiration for and an interest in medicine. With a lot of hard work and the support of loving parents that little girl, as an adult, has the ability to humbly and respectfully come before you today as a neurologist, as committed as my predecessors to providing the best possible health care for my patients.

Senator Bumpers, I am thankful to have had his opportunity to share some of my professional concerns with you. On behalf of the neurologists, the subspecialties in neurology, and other medical specialists, I would ask you to help us maintain and improve upon the best medical care system in the world. The good medical care I strive to provide and the quality of life of my patients are at stake. I offer you my help in the upcoming months as you and other leaders make vitally important decisions concerning changes in health care delivery and the financial impact it will have on our citizens. Thank you.

[The prepared statement of Dr. Corbitt follows:]

PREPARED STATEMENT OF MARY LOUISE CORBITT, M.D.

Senator Bumpers and Staff: I am Dr. Mary Louise Corbitt, a board certified neurologist and co-founder of the Neurology Group and the Arkansas Headache Clinic. As a lifelong resident of Arkansas, I graduated from Hendrix College and the University of Arkansas School of Medicine where I completed my neurology residency in 1976. I served on the clinical faculty as assistant professor of Neurology until I entered private practice. My practice had been devoted to general neurology until 1987 when I co-founded the Arkansas Headache Clinic. Since that time I have devoted my practice to the evaluation and treatment of patients from Arkansas and surrounding States who suffer from debilitating head pain and related disorders.

I come before you today on behalf of the neurologists of our great State and on behalf of our patients who suffer from a myriad of very complicated and often debilitating medical illnesses such as headache, epilepsy, multiple sclerosis, Parkinson's disease and Alzheimer's disease. These neurological illnesses as well as other chronic medical illnesses, such as diabetes and heart disease, require special consideration in any health care plan. Early diagnosis and effective medical management are critical to achieve cost containment and meaningful health care benefits. Any comprehensive health care plan must address the treatment realities of patients with these chronic illnesses.

In addition to my oral testimony, I would like to submit for your consideration the Principal Care Statement issued September, 1993 by the American Academy of Neurology (Document A). The concept of principal care refers to the ongoing care of a patient provided by a specialist for the patient's principal illness. The Academy of Neurology strongly encourages those entrusted with the crafting of our future health care plan to include this important concept of principal care within the plan. Neurologists, as the principal care providers for neurological illnesses, are the only providers who have the necessary training, knowledge and experience to provide cost efficient diagnostic evaluation, treatment and management for these disorders.

I would like to devote the remainder of my remarks to headache, which is the most frequent occurring and most frequently misdiagnosed and mistreated neurological disorder. Over 40 million patients suffer from headache in the United States. A headache is invisible, yet it severely impacts the quality of life and every day function of anyone who regularly lives with this chronic disorder. Those who suffer from headache are much less likely to be referred to a neurologist or headache specialist than is a patient suffering from epilepsy, multiple sclerosis, Parkinson's disease or Alzheimer's disease.

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In the specialty treatment of chronic headache, secondary prevention includes the prevention of a host of common problems seen in the headache patient. These include the development of unnecessary drug dependency, needless surgery, redundant testing, unnecessary hospitalization, disability, depression and even suicide. All of these potential problems encountered in this chronic illness may be reduced or totally prevented by effective treatment, and when necessary, utilization of coordinated systems of outpatient and inpatient care. Treating these patients appropriately and early after onset of chronic headache has the potential to save millions of dollars in health care costs as well as loss of productivity in the workplace. It is also the only way to efficiently provide and restore long-term quality of life to a chronic headache sufferer.

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To further illustrate the personal impact and magnitude of chronic headache and the necessity for early principal care provider referral I also include for your review the attached brief case histories from our clinic (Document 8), a poignant letter from a patient (Document C) and a few dramatic facts concerning headache (Document D).

In closing, I would like you to join me for a moment in returning to a time when the moral obligations of the physician were his or her guiding force, and not financial disincentives or external pressures. The year was 1951 and the patient was a snaggled tooth little girl, the only child of a very hard working couple of modest means. The child developed a high fever. The family physician referred her to a pediatrician. The pediatrician referred the little girl to a cardiologist. The diagnosis was rheumatic fever.

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tally from within, based on his medical knowledge, his concern for his patient and his moral obligation to provide that patient with the best medical care available.

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Senator Bumpers, I am thankful to have had the opportunity to share some of my professional concerns with you. On behalf of the neurologists, the sub-specialties in neurology, and other medical specialists, I would ask you to help us maintain and improve upon the best medical care system in the world. The good medical care I strive to provide and the quality of life of my patients are at stake. I offer you my help in the upcoming months as you and other leaders make vitally important decisions concerning changes in health care delivery and the financial impact it will have on our citizens.

RECOMMENDATIONS

I. Inclusion of the principal care giver concept into the health care plan. The plan must not encourage denial or delay of referral from the primary care giver to the principal care giver.

II. Insure the inclusion of secondary prevention into the health care plan. Early management of a complex illness such as headache or diabetes will prevent costly complications and prevent deterioration before irreversible disability and regression occur. Primary prevention alone is not adequate.

III. Adopt a system of staging of sufficient simplicity to allow payors, government agencies and health care professionals effective use for purposes of referral, case supervision and quality assurance review.

Example: All patients with recurring headache would not be appropriate for referral from a managed care or primary provider. However, a patient with frequent or persistent headache, complicated by addictive disease, overutilization of services, disability, frequent hospitalizations, etc.,would be staged at a more advanced level, and determined to be a higher risk patient, thus prompting referral.

IV. Match the intensity of the clinical service to the severity of the illness. It is a worthy goal that patients with chronic and complex disorders have the intensity of their clinical service appropriately matched to the severity of their illness. The goal of staging would help assure that chronic complex illness is effectively treated when it will provide the maximum clinical and cost effective benefit.

DOCUMENT A

STATEMENT OF PRINCIPAL CARE

Reprinted from the Medical Economics and Management Subcommittee of the Practice Committee of the American Academy of Neurology

"The concept of principal care refers to the ongoing care of a patient provided by a specialist for the patient's principal illness or set of related problems. Principal care is not primary care, which is comprehensive care, usually provided by generalists. It is also distinguished from consultative care, which refers to an evaluation of a patient and provision of recommendations and advice to another physician without ongoing management. Patients with diagnoses such as epilepsy, headache, movement disorders, dementia and related disorders, multiple sclerosis, among many others, often require continuing management by specialists. These problems may occur in individuals who do not need to seek primary care on a regular basis. Furthermore, these disorders are often sufficiently complex that it is difficult for primary care physicians to provide optimal evaluation and management.

From an economic standpoint, the neurologist's visit reimbursement is the same as that of primary care physicians. Moreover, neurologists, because of their experience and fund of knowledge are likely to identify the most cost effective diagnostic and management interventions for neurology disorders.

The American Academy of Neurology encourages health care planners to include the concept of principal care models of health care delivery."

DOCUMENT B

CASE EXAMPLES

Man, age 47—Chronic cluster migraine headache for over 10 years—Taking daily narcotics and presenting to ER once weekly for narcotic injection. On medical leave

from work. Suicidal and desperate; helpless feeling after seeking medical treatment from many sources.

Outcome—Pain free; back to work and non-addicted.

Young woman, age 15—Suffering last 12 months with daily headache often accompanied by confusion, nausea and dizziness; taking 12 ES Tylenol daily. Missed school 7 days in 2 months. Pediatrician referred but insurance companyinitially refused to authorize visits. Finally approved visits.

Outcome—Not missing school; pain much less severe and avoiding overuse of Tylenol.

Woman, age 41—Suffering from severe and frequent headache for 10 years (20 days per month with headache); taking 4-5 Tylenol with Codeine daily for 4 years and 3-4 narcotic injections monthly. Averages 3 days of missed work permonth.

Outcome—Headaches are rare and mild; non-addicted and no missed work.

Woman, age 30 and pregnant—Suffering from complicated migraine associated with partial paralysis of arm and leg. Patient enrolled with managed care organization and primary care physician refused referral to specialist for continued treatment.

Outcome—Hope to be able to provide care and treatment as principal care giver.

DOCUMENT C

239 DESOTA STREET,
WEST HELENA, AR 72390,
November 5, 1993.

Dear Dr. Corbitt, I have suffered with headaches for over 20 years. These headaches seemed to increase as I grew older. My family physician prescribed medicine for these headaches for numerous years but after his retirement, doctors were reluctant about prescribing medicine for these headaches or they felt that I was not having them everyday like I said.

Finally, I went to a female doctor, Dr. Sandra Nicholas, who knew about the clinic. Before going to Dr. Nicholas, I had already been to two neurologists.

For the first time in over 20 years, I wake up pain free. The first time, I woke up pain free, it scared me. I will never forget you. I did not know that I could live pain free. I had adjusted to a certain amount of pain. I went to the doctor only when the pain became so severe it impeded my ability to function.

Three years ago, I returned to professional school to obtain a second master's degree in counselor education. While there, many times, I would have to spend approximately $90 at a clinic in Jonesboro just for a shot to kill the pain.

Within a month, you had discovered the causes of the headaches and begun to treat them. Many, many thanks to you.

A counselor is taught to give/share. You will find enclosed two small picture cards of African art of which I am a collector to hang in your office. Every time you look at these pictures, I want you to remember this pain free patient. God healed me through you.

Yours truly,

ULYSSES JEAN WILLIAMS.

DOCUMENT D

FACTS ABOUT HEADACBE

Forty million patients suffer from recurring headache in the United States.

Over 90 percent of those who suffer from headaches regularly never see a specialist who might be able to help them.

Eighty percent of those not effectively treated experience periodic disability.

Seventy-six percent of women and 57 percent of men surveyed in a nationwide study experienced at least one significant headache in the monthprior to the evaluation.

Lost productivity and time for the U.S. work force is estimated at $6.5 to $17.2 billion a year.

Between $4,000 and $7,000 are spent annually by an employer for each migraine sufferer.

Between 1980 and 1989, there was a 60 percent increase in the prevalence of migraine.

The CHAIRMAN. Thank you very much. That is a great statement. We will come back to that in a minute, I have got a story I am

going to share with you along the lines of the one you just told. Dr. Baker.

STATEMENT OF DR. GLEN BAKER, PRESIDENT OF THE ARKANSAS MEDICIAL SOCIETY, LITTLE ROCK, AR

Dr. BAKER. I am here representing the Arkansas Medical Society. I am a graduate of the University of Arkansas, and I graduated in 1959 from medical school. I am a native of Jackson County from the small town of Grubbs, with a population of 380. 380 when I was there as a youngster and 380 now. It has not grown significantly.

I have practiced for 10 years in Jonesboro, AR, before coming to Little Rock. I am a board certified pathologist. In fact, I served as professor of pathology and director of laboratories at Children's Hospital and at the American Red Cross. I assumed the presidency of the Arkansas Medical Society in May of this year.

The CHAIRMAN. I was trying to think of where we first met, Dr. Baker. Where was it?

Dr. BAKER. I can tell you, Senator, you were Governor. You were concerned about the health care being delivered at the Tubercular Sanitorium up in Booneville, AR. You called upon a small committee to make a nonscheduled site visit to that facility. You asked me, as a member of that team, to participate. We made the visit to Booneville.

The CHAIRMAN. Booneville.

Dr. BAKER. Made our recommendations to change the method in which tubercular——

The CHAIRMAN. To carry them out.

Dr. BAKER. —patients with tuberculosis were treated in the State of Arkansas. You accepted that recommendation and acted upon it.

The CHAIRMAN. Which was to close the facility.

Dr. BAKER. To close the facility and——

The CHAIRMAN. It really made me a lot of votes in Booneville, too.

Dr. BAKER. But it was good for the health of the citizens of the State of Arkansas, there is no question about that.

The CHAIRMAN. It really was.

Dr. BAKER. I assumed the presidency of the Medical Society in May of this year, and would simply indicate to you the breadth of knowledge I have as to what is happening in the State comes from having visited since then with the medical communities in Helena, Fayetteville, West Memphis, Batesville, Heber Springs, Camden and El Dorado. And for this month I have scheduled visits to Magnolia, Arkadelphia, Clarksville and Blytheville. So, my attempt is to obtain some understanding of what concerns physicians in the State of Arkansas as far as health care.

The four major issues that have surfaced in these visits has been the cost of practicing medicine and the reimbursement received for that time and effort, tort reform, anti-trust issues, and problems with access.

I would like to address, if I may, the issue of cost first. I think a large part of the discussion today, and as is true with these forums around the country, they are centered primarily around the high cost of health care and the methods to contain this cost. I think the

first pronouncement should be made that whether there is any significant legislation on the State or national level, significant strides are being made in reducing health care costs, without a question, that is true.

The Clinton proposal and the media attention that it has generated has served as a catalyst for voluntary efforts to curb health care costs. Health care providers have become much more attuned to and cost conscious with their utilization of referral patterns and the emphasis on managed care is taking this country by storm. We are all recognizing that. Physicians are being inundated with proposals from managed care entities, all of which involve reduced fees and reduced utilization.

The Arkansas Medical Society has itself initiated the development of a statewide physician network designed basically to provide budget conscious health care to both business related and private patients. The result of this managed care mania and the activity it has generated is being reflected by the new statistical data that does indicate a reduction in health care costs.

I would ask that you and your colleagues in Washington recognize that physicians of this state and of this country share your concern about the high cost of health care, but we cannot be held responsible for the poor lifestyles of Americans which cost $100 million in annual health care costs due to alcohol and tobacco related illnesses. We cannot be held accountable for the public failure to wear seat belts or motorcycle helmets. The cost of care for these individuals involved in traffic accidents in the State of Arkansas alone this past year was $200 million.

We cannot be held accountable for companies that do not practice safe work habits, resulting in an increase in incidents of Workers' Compensation claims. We are concerned about the high cost of defensive medicine, the figure of $60 million per year is quoted. I think that is a gross understatement of the cost of defensive medicine. We feel that it increases physician's charges by at least 25 percent. This liability threat is affecting public access to good medical care, as I mentioned in the previous presentation.

There are 27 counties in Arkansas at last count where not a single physician was providing maternity care, and much of that failure to provide maternity care is attributed to an inability to obtain adequate or affordable malpractice coverage. It is a critical area, tort reform must be addressed.

As an aside, Governor Tucker in his health care task force, has established a tort reform malpractice subcommittee. I have been asked to chair that subcommittee, and we will be bringing forward some recommendations for tort reform that we feel will have a major impact upon reducing the cost of health care and that we think might possibly get through the legislature.

The CHAIRMAN. Dr. Baker, let me just interrupt you one moment. Do you think that is essentially a State problem, or do you think the Federal Government ought to address it?

Dr. BAKER. I think there are some guidelines that need to be established at the Federal level, yes, sir.

The CHAIRMAN. We have always been reluctant to get into anything dealing with the tribunal of the State laws. That has always been the prerogative of the States.

Dr. BAKER. I understand that.

The CHAIRMAN. I recognize that malpractice is a very big problem, and you heard Dr. Jackson testify a moment ago.

Dr. BAKER. Yes. And his statements are absolutely correct and are multiplied many times throughout the State on a regular basis, no question about it.

The CHAIRMAN. Some States are addressing it, some States have done something about it.

Dr. BAKER. That is correct. And we will attempt to deal with that at the State level, but I think that it will require that there be some national change required.

The CHAIRMAN. Sometimes there needs to be at least some kind of a change.

Dr. BAKER. At least a stimulus.

The CHAIRMAN. At the Federal level.

Dr. BAKER. Yes, sir.

The CHAIRMAN. Go ahead, I am sorry.

Dr. BAKER. I would point out to you that we wish sophisticated diagnostic equipment such as MRIs or lithotriptors were not so expensive, but we know that they are, we know that the public enjoys and demands these miracles of modern medicine. If they were to continue to develop these new technologies that indeed are miracles, that there must be some mechanism for compensation for those that develop this type of equipment and we must not ignore that.

As I stated, as I travel around the State, I find that the physicians are concerned basically with the manner in which health care is being organized, or the delivery of health care is being organized at the State of Arkansas. It basically requires three elements. It requires a payer, it requires someone to deliver that care, whether it be a nurse practitioner or a physician, and it requires a facility in which that care can be delivered.

We are seeing around this state and in many other states, a collapsing or a blending or a partnering, if you will, of the payers and the facilities with the physicians being left standing aside as an unequal partner in this three-legged stool of health care delivery. They are being left standing aside basically because of our fear to actively come together as an organized body, because of the antitrust issue.

There must be something done to deal with the antitrust and the inability of physicians or physician groups to come together in some mechanism to address health care in a uniform manner.

Senator I thank you for being allowed to appear before you, and thank you.

The CHAIRMAN. I have not heard that issue mentioned before, but we will make a note of that, because that is a very good, cogent point you made.

Dr. BAKER. It is critical, it is absolutely critical, Senator.

STATEMENT OF DR. JIM WEBER, PRESIDENT-ELECT, AMERICAN ACADEMY OF FAMILY PHYSICIANS, JACKSONVILLE, AR

Dr. WEBER. Senator Bumpers, I am Jim Weber from Jacksonville.

The CHAIRMAN. Jim, you know something, this morning we were talking about all of those great exploits when I was Governor, about what we did at the Med Center and for primary health care. The one thing that we did do that did last is the family practice department out there. It is one of the greatest moves we ever made.

Dr. WEBER. Yes, it is one of the great programs.

The CHAIRMAN. Go ahead.

Dr. BAKER. Dr. Jackson makes me very proud to be a family physician. Certainly, in rural America, 80 percent of the doctors throughout rural America are family physicians. And the Health Care Security Act does have some very good options for training more family physicians. We do have 74,000 members, including residents and students. That is not nearly enough to meet the needs of the health care reform. What I would like to do, briefly, is to cover some very important basic principles that we believe in in health care reform and also mention some of the areas that have not been touched upon by the other speakers.

We all acknowledge that it is necessary to bring health care costs under control. I would like to emphasize to you that an essential component in that effort is the elimination of uncompensated care and cost shifting. This requires that every individual have health insurance coverage, and that all payers pay their fair share, including Medicare.

While it would be nice to bring costs under control first, and then cover everyone, it is, in fact, not possible to do that. Universal access to health insurance then for all Americans is basic to health care reform. In regard to insurance reform, it is reassuring to me, at least, that both political parties seem to agree on most of the important aspects of insurance reform which was mentioned here. To be uninsurable, or to change jobs and lose ones insurance, or to be saddled with a myriad of preexisting insurance illness clauses are insecurities that are really no longer acceptable.

I highly believe and favor the comprehensive package of benefits which emphasize prevention and early diagnosis. Tragically, the most dreaded diseases in our society which are often preventable cause no symptoms until late in their course. The emphasis on prevention will cost slightly more in the short run; but in my opinion, it will provide major financial savings in the long run. The great benefit in human suffering and lives saved by this change in health insurance philosophy is revolutionary, and we do highly support that.

As to the employer mandate versus the individual mandate versus no mandate, we support employer-based insurance coverage rather than the individual mandate because it builds on the current system of insurance marketing and availability, minimizes costs, and minimizes disruption in transition to universal coverage. Significant subsidies, however, must be made available to assist small businesses in meeting the cost of health insurance. We also believe there should be significant employee cost sharing requirements that induce price sensitivity among patients.

I want to say just a word about the financing cuts proposed in Medicare in the Clinton plan. As you know, the President proposes to raise much of his planned revenue through $124 billion cut in

Medicare spending. The fact is that Medicare fees for office visits in most parts of the country today are less than the cost of providing that service. Medicare payment reform is supposed to have fixed this, but because of the way it was implemented, it did not. Here in Arkansas, Medicare pays less than half of the cost for office visits for the family physicians and primary care doctors practicing throughout the State.

This has been a major factor in driving the cost of health insurance in the private sector up to the point where it is not affordable. If we are going to have meaningful health care reform, this problem must be addressed and corrected. We are afraid that Medicare beneficiaries will increasingly experience access problems as they now are experiencing here in the State of Arkansas.

We have deep reservations about putting too much reliance on Medicare cuts to fund universal health insurance. It makes little sense to jeopardize the access of health care to one segment of society to ensure access to another. Funding universal coverage should be through a broad-based and progressive mechanism such as a national sales tax or an added value tax.

There are several other factors that I could address, but today I will address the one of regulatory relief. We do not see significant regulatory relief for physicians in any of the health care proposals now before Congress. There must be major relief in the OSHA and CLIA regulations, and serious reduction in the ocean of paperwork that buries most of us today. The average family physician spends approximately 30 hours per month doing paperwork—time which could be better spent taking care of patients.

The huge overdose of Government regulations pertaining to Medicare and Medicaid accounts for the majority of paperwork and administrative hassles that we see from day to day. Physicians worry about more instead of less Government in reform. There must be relief, but we do not see it in most of the plans as now written. The expense of this unproductive work is huge. The Government and third party payer schemes to discourage patient care in the name of cost containment are a major hassle in today's system, and are, for the most part, counterproductive.

Thank you. That is all I will comment on.

The CHAIRMAN. Dr. Weber, you heard Dr. Jackson testify awhile ago that he spends, what, 3 hours a day, average, filling out papers?

Dr. WEBER. I am sure he does.

The CHAIRMAN. How many times have you heard Bill Clinton and Dale Bumpers and all of the rest of us talk about 24 cents out of every health care dollar in this country going for administrative expense? Twice as much as any other developed nation on Earth. Now, you do not have to say anything except to say, "That is an outrage and it is unnecessary." It may create a few jobs and you have been around long enough, as I have, to know that so much of that never is seen, nobody looks at it.

It is like these bank examinations, they fill out all of these forms and papers and they send it in and nobody ever looks at it, it is just a requirement designed to keep them on their toes. Unless we are going to seriously deal with that problem, get in line with Canada and Japan and Germany and their administrative costs—

the other night I was at one of those fancy parties at one of the embassies in Washington, and I sat beside a doctor's wife, who by her own admission was probably the most brilliant person I had ever met.

And she said, "No, that is not a problem." Every time I suggested it, "No, that is not the problem." Finally, I said, "Well, what is the problem?" I said, "Every time I walk into a doctor's office, I see this as not sexist, but I see a bank full of women back there pounding typewriters and so on filling out forms. Somebody is paying for that, and I know who is paying for it."

"Well, that is not what is driving up the health care costs." I said, "Every statistic I have ever seen shows 24 cents out of every dollar, which Canada and all of the rest of them spend anywhere from ten to 12 percent. You have these statistics, incidentally, if you have five employees, your premium is going to be 40 percent higher, because it takes 40 cents of every dollar to administer a policy that small. If you have 500 or more, it would cost five cents on the dollar to administer a policy that large."

She said, "No, that is not it. It is these women having crack babies." I said, "Well, that is a problem, all right." She said, "You know, I do volunteer work down at Children's Hospital here in Washington." Her husband, incidentally, is a fairly prominent surgeon in Washington. And she said, "I do volunteer work, and when these women come in and have those crack babies, they leave them with us for 2 months, it is not uncommon for them to leave there with a million dollar bill."

Well, I guess in summary, you can say, yeah, that is a problem, it certainly is a problem. Anybody in an obstetrical situation knows that. And my daughter worked in the premature baby section of the Med Center one summer when she was in college, and I went out and visited with her a couple of times. And I must say, that was shocking there, I never dreamed.

That is a tremendous drain on the medical system, those preemies, I might also say that is the reason I vote for things like WIC, to give a woman a decent, nutritious diet while she is pregnant, because you enhance the chance that she might have a healthy baby as opposed to a low birth weight baby. Boy, they are expensive. But do not tell me when we are at 24 cents on the dollar we cannot save tens and tens of billions dollars. So, you really hit a nerve with me on that.

And Dr. Corbitt, I had a young fellow who is brilliant; happily he came back to Little Rock, neurosurgeon, I knew him because he had interned with Senator Pryor's office on one of those summer internships for college kids many years ago. Now, he is a really bright, fine youngster, and he has been back here a year and a half. He finishes his neurosurgical residency. He studied in Switzerland and came back. And we are so fortunate to have a youngster like him here.

But he showed me a bill of a patient that came to see him. And the first thing that his first doctor had done was to put a hot pack on the back of his neck for a headache. And he came back every day for 60 days, and I saw the bill, $50 a day for a hot pack on the back of his neck. Finally, he was hospitalized, that was 2 to 3 days,

$7,000, and he still had a headache. He finally came to see this neurosurgeon, and in a matter of 30 minutes, he had it diagnosed.

Now, I hate to tell that story, because I think we have too many specialists. That is driving health care costs in the country up obviously. But you alluded to that very same problem in your testimony. I do not know what you can do about that, but sometimes it is better to send somebody to a specialist on the front end than it is to muck around with them and then wind up going to a specialist.

Well, it is such a multifaceted problem, and we are trying to attack all of it at one time. But I want you to know that in my 19 years in the Senate, this has been one of the most interesting and instructive days I ever had. I have loved every minute of it, because it is not often I get the time, frankly, to sit and listen to people like you who really know what you are talking about, who deal with the hands-on part of this issue every day, and can tell people, "I like to think that I have a certain degree of common sense and I know what you are saying, and I am receptive to it." And it helps me mightily in my deliberations on this.

As I say, this is principally for the small business community, but I did not want to just limit it to that, because I want to hear the rest of you, too. And Glen, that was a very tough thing you all asked me to do back in 1972 or 1973, but it was the correct thing to do.

Dr. BAKER. Yes, sir.

The CHAIRMAN. And we did it. And we have to do something. It is a tough thing for me and I wish from a political standpoint, this thing would go away. I can promise you, I am not going to make any friends with it, and nobody else is, but everybody feels it is something we have to do. What we are trying to do is use our common sense, based on our years of practical experience and say, "Yes, this will work. No, this will not work," and come up with something that will be at least better than what we have now.

Does anybody wish to add anything to what you have already said? I thank you so much for being with us this afternoon. I promise you your words will go in the record, it will be shared with the other members of the Committee, it will be extremely helpful to me, whether anybody on the Committee other than me looks at it or not. Thank you very much.

The CHAIRMAN. Our final panel this afternoon are the consumers; Herb Bingaman, president of Arkansas Seniors Organized for Progress in Little Rock; Cecil Malone, state director, AARP, Little Rock; Johnnie Pugh, state chairwoman, Association of Communities Organized for Reform Now, ACORN. Herb, welcome.

Mr. MALONE. How are you?

The CHAIRMAN. Better than I deserve. How are you doing, Cecil? Just a moment until Johnnie can get here. Herb, your name is first on the list, so please proceed.

STATEMENT OF HERB BINGAMAN, PRESIDENT, ARKANSAS SENIORS ORGANIZED FOR PROGRESS, LITTLE ROCK, AR

Mr. BINGAMAN. Thank you, Senator. I sat and listened to the panel earlier about Eudora and Chicot County, and I will tell you, I think that is where you maybe ought to go down and hold some

hearings and take the whole Senate down there and hold the vote down there. I really think that they might have a different view of this whole health care situation.

The CHAIRMAN. We are too busy being political about this to deal with the real problems.

Mr. BINGAMAN. Good morning, Senator, my name is Herb Bingaman, and I live in North Little Rock, AK. I am the president of Arkansas Seniors Organized for progress, ASOP, a statewide organization working with seniors for quality, affordable health care. I am going to just touch on my testimony, we have already submitted it to you, sir.

Health care is consuming a big portion of the average family's income. A recent study by Families USA found that this year Arkansas families will pay an average of 16.3 percent of their pretax incomes for health care, the third highest figure in the nation. That is one dollar out of every six, Senator.

The CHAIRMAN. Now, wait a minute. You are saying Arkansas is the third highest in the nation?

Mr. BINGAMAN. Yes.

The CHAIRMAN. Go ahead.

Mr. BINGAMAN. Unless we reform health care, families and businesses will continue to spend a larger and larger share of their incomes on health care. As you said last year, Senator, we are already paying for national health care, we are just not getting it. Long-term care is probably the seniors' greatest worry, followed by prescription drugs. Long-term care, Medicare and health insurance do not cover most long-term care, and long-term care insurance is unaffordable for most seniors, and often provides inadequate coverage.

As a result, an estimated 97 percent of Americans have no long-term health care insurance provided, and their families have to take care of their needs at that point. Many retired Arkansans find that even after they enter a nursing home and spend down their savings, they are ineligible for Medicaid because their pensions and Social Security put them over the income limit. We call these "pension penalties."

Prescription drugs, the high cost of prescription drugs is another concern to seniors. The fact that drugs are so high creates a problem to where many people have to go back to the doctor much more frequently because they cannot afford to buy the drugs and they just have to continue to go back. Medicare beneficiaries and other Americans should have insurance coverage for prescription drugs. Americans are tired of paying the highest prices for American-made drugs, while people in other countries buy the same drugs at discount prices. I personally went down to Mexico and checked on the cost of drugs, and you can buy them across the border in Matamoros for about a tenth of what you pay for them here in the United States, the same brand drugs.

Early retirees and disabled workers. Health insurance is a big problem for early retirees and older workers who have not turned 65 and are not yet eligible for Medicare. It is very difficult for early retirees to purchase health care insurance. If they are healthy, their premiums are still high because of their age. If they have health problems, they cannot buy it at any price. And many corpo-

rations today are forcing people out because of the layoffs and trying to develop cutbacks in the workforce. Another group which has severe problems are workers who qualify for Social Security disability insurance. They are not eligible for Medicare until at least 29 months after their disability begins, and often they are uninsured during this period of time. That is a very serious problem.

Doctors refusing to treat Medicare patients. A growing concern for Medicare beneficiaries is access to physicians. I have personally been turned away. I know the problem in North Little Rock, AR, and we have had complaints from all over the State.

Medicaid recipients should be "mainstreamed". One big problem is access to physicians, which is often hindered by low Medicaid payments to providers. As a result, Medicaid recipients are often forced to use emergency rooms to obtain care which is extremely costly.

Cost sharing, a burden for low income people. Congress has already helped low income Medicare beneficiaries by "buy in" to Medicare, by paying their premiums, deductibles, and copay through Medicaid, qualified medical beneficiary, and SMB, specified low income Medicare beneficiary programs. These programs need to be continued and expanded, and we hope that they will continue to be a part of the system.

Health security for our families. Seniors would like health care security, not just for themselves, but our children and grandchildren. We know that unless we have a system of universal health insurance, some Americans will continue to use their insurance and others are likely to have inadequate benefits. We also know that as long as there are uninsured people, there will be cost-shifting.

Another point, Senator, not in my statement here, but, people that work are paying 7.65 percent of every dollar they earn, and many of these people are unable to have health insurance and they are helping to pay that to keep programs going for Social Security and health care for seniors, plus a lot of out-of-pocket tax money. Single-payer, we believe the best way to accomplish our goals is through a single-payer system, as Senator Wellstone, Congressman McDermott and others have proposed. For seniors, national health insurance is not a radical system. We already have it, Medicare.

I want to say that I understand the serious problems with getting a single-payer system going, but it really would be the best in the long run, if it is possible and politically feasible.

President Clinton's plan incorporates many positive features of the single-payer approach, while preserving a system that most Americans are accustomed to, employer provided private insurance. Under the Clinton plan, all Americans would have insurance, and could choose their insurance plans. Insurance companies could never take away their insurance or reject you. Cost would be controlled, so insurance would become more affordable for many Americans.

Under the Clinton plan, seniors would benefit in many ways. Medicare coverage of prescription drugs, a new home and community health care program to keep people out of nursing homes. Frankly, Senator, that could be done an awful lot less expensive than what we are currently paying for the nursing home system.

The CHAIRMAN. Now, you know home health care is covered under the program?

Mr. BINGAMAN. Yes, sir. Changes in Medicaid eligibility, to allow people who cannot pay their nursing home bills to qualify for help; a requirement that doctors accept Medicare as reasonable charges as full payment; guaranteed affordable insurance for early retirees and disabled workers; meaningful cost controls; health security for all children and grandchildren.

The Clinton plan is not perfect, but if you look at a plan like Senator Chafee is proposing, it is tremendously better. We think that that is a real step in the wrong direction.

I would like to say one additional thing, Senator. Comprehensive universal health care is what we really need here in America, and we have got to find a way to do it as soon as is humanly possible. I thank you for the opportunity to be here with you today.

The CHAIRMAN. Thank you very much, Herb. Just before we go to you, Cecil, I might tell you that when I ran for Governor the first time, Herb Bingaman was head of the United Auto Workers, and had been for years, and nobody knew who Dale Bumpers was and did not care. And the UAW was having their convention in Russellville, I think the Ramada Inn.

Mr. BINGAMAN. That is correct, sir.

The CHAIRMAN. And they had their regional representative, Ken Worley from St. Louis. And Ken wanted to put me in my place and did. He said, "Now, tell us, Mr. Bumpers, if you were Governor, let us assume we have a riot, people out in the street shooting each other, fire bombs in the buildings, the town is on fire, and the fire fighters were out on strike and the police are on strike and the hospital workers were on strike, what would you do?"

I thought a minute, and I said, "I do not know, but I would do something." Ken always said, "That is about as good an answer as any." I have enough native intelligence and experience in the trial of law, I used to tell my clients and witnesses, "There is no better answer than, 'I do not know,' because it is, 'I do not know, but,' that gets you in trouble." So, that night Ken and I became fast friends and we have been friends ever since.

Mr. BINGAMAN. I remember the discussion.

The CHAIRMAN. You remember that, Herb?

Mr. BINGAMAN. I sure do, sir.

The CHAIRMAN. Cecil.

Mr. MALONE. Well, I think after you said that, I should start off by telling you, you have given me trouble for a lot of years. My wife was coming down the stairs at Pulaski Heights Methodist when you were Governor and she tripped and you caught her, and she has always said, "You would have probably let me fall."

The CHAIRMAN. I was in church and I was a good Christian.

STATEMENT OF CECIL MALONE, STATE DIRECTOR, AARP, LITTLE ROCK, AR

Mr. MALONE. I am Cecil Malone, the Arkansas State Director for AARP, and I want to thank you for this opportunity. I would like to give you some written material. I have been out of the State, and I just got back yesterday. AARP believes that the comprehen-

sive health care reform is essential for a sound economy and for Americans' health security.

The President has put forth a strong proposal for comprehensive reform, which aims at controlling rising health care costs, and at the same time provides universal coverage. He has included long-term care, prescription drugs and coverage for early retirees in the bill. These are critical components as far as AARP is concerned. And as you know, Senator, AARP has, in the last 3 years, gone out and surveyed a lot of people. And our 321,500 people in Arkansas have really gotten behind health care reform and they are interested in proceeding at this stage.

Many members of Congress have put forward reform proposals, and we are very pleased about the bipartisan commitment to reform and pledge to work with members on both sides of the aisle toward a reform package that provides universal coverage for a comprehensive benefits package that includes long-term care and system-wide cost containment.

I want to focus on just a few points. Health care coverage must not only be available to all, it must be affordable, as well. And the present plan asks all employers, as well as the employees, to contribute to the cost of the coverage. AARP strongly supports this approach. This mandate would help to level the current uneven playing field where some businesses, including many small businesses, pay more than their fair share, while others are paying nothing. More importantly, employers' contributions are critical to achieving universal coverage without substantially increasing the Federal taxes. And health care reform is both a complex national issue, as well as a highly personal issue.

Rapidly growing health care costs now rob our nation's economy, businesses, and families of the financial security which we all need to prosper in the future. Controlling health care costs throughout the entire system must be a central goal of health care reform, and the Medicare program can be expected to be a part of that effort. But the magnitude of the proposed savings in the present plan, $124 billion, is alarming on its face value. Over the past decade, Medicare has absorbed roughly $200 billion in cuts, $56 billion just this year, and the program now pays an average of only 65 cents on the dollar, compared with the private payers. I believe Dr. Weber, just before that, said only about 50 percent.

So, increasingly, our members tell us that they are paying for these Medicare cuts in reduced access and reduced care. And a critical question for the association and its members is whether the President's proposal and any other reform proposal will reduce the Medicare private payment gaps and begin to address Medicare access programs. Without some system-wide cost containment, the association will oppose further efforts to cut Medicare. AARP is also concerned that the present plan would provide worse coverage for Medicare beneficiaries than for the younger population. For example, Medicare beneficiaries would not have an annual limit on total out-of-pocket spending, and low income protection would remain inadequate.

Also, the President's proposal to establish home health and lab co-insurance, as well as the technical outpatient hospital savings measures, would create significant hardship for many Medicaid

beneficiaries, particularly those in the very lowest of incomes. Now, if Congress decides to grant a limited number of states the authority to integrate Medicare for a broader statewide system, the association urges that states be required to demonstrate through thorough Federal oversight, not simply an assurance, as in the bill, that Medicare beneficiaries will receive the same benefits as the under 65 population, and that Medicare funds are earmarked so that states cannot divert such funds for other purposes.

We are not convinced that states could handle a takeover of the Medicare program, it would take time for states in alliance to learn how to run a new system without adding 35 million more people to the payroll. AARP is particularly pleased, however, that the President's proposal includes a new program for home and community-based care for persons of all ages and incomes. This is a major step forward. We do, however, have some specific questions and concerns about the proposal. The proposal, in effect, is a cap grant to the States.

But now, how would this work? Would funding be subject to annual appropriations? How would it happen if the program ran out of money before the end of the physical year? Would service to persons currently receiving care simply be cut? The plan also changes in Medicaid nursing home coverage and new Federal standards for long-term care insurance. While AARP supports the plan's modest Medicaid improvements to require that all states have a medically needed program and to allow states to raise the assets limit with restricted Medicare eligibility, millions would still remain unprotected against those expensive costs in long-term care services.

In conclusion, AARP commends the President and members of Congress of both parties who have brought health care reform to this stage. We recognize that reform may need to be passed in over a number of years, and that adjustments will be needed along the way, but we must have comprehensive health care.

In closing, if there is one thing we should all agree on, it is that the status quo is not acceptable. Thank you very much, Senator.

[The prepared statement of Mr. Malone follows:]

PREPARED STATEMENT OF CECIL MALONE, ARKANSAS STATE DIRECTOR

Good morning. My name is Cecil Malone, I am the Arkansas State director for the American Association of Retired Persons (AARP). Thank you for the opportunity to testify today as the subcommittee probes the public commitment to health care reform and reviews the President's plan.

As a membership organization of 33 million older Americans, AARP has a long-standing and profound interest in this debate. Roughly half of our members are between the ages of 50 and 64; the other half are over 65. Approximately one-third of our members are still in the workforce.

Over the past few years, we have listened closely to what our diverse membership and their families want in a health care system. Despite their differing circumstances, the vast majority of Americans, old and young, have stressed a need for broader protections against the high costs of health and long-term care.

A few months ago the President stood before Congress and the American people and pledged his leadership in fixing our broken health care system. He called on members of both political parties to seize the "magic moment" of opportunity by enacting universal and comprehensive health care. AARP commends President Clinton for his bold and constructive plan for accomplishing reform. We also commend the First Lady, Congressional leaders in both parties, and this subcommittee for a commitment to addressing this issue now. We believe that true reform must cover

everyone, maintain high quality, make health care costs affordable, and include vital prescription drugs and long-term care.

Comprehensive health care reform means:

- A guarantee that all individuals have access to and coverage for health and long-term care;
- System-wide cost containment that slows the explosive growth in health spending;
- Comprehensive benefits, from prenatal care and prevention to prescription drugs and long-term care;
- Consumer-centered governance of the health care system; and
- Broad-based, fair and affordable financing, so that government, businesses, and individuals all pay their share and everyone is protected against the high costs of care.

While AARP has not yet endorsed any specific health care reform plan, we believe the President's proposal provides the strongest and most realistic blueprint to date for achieving our goals. We are particularly pleased that the President has included the following critical provisions in the Health Security Act:

- a home and community-based long-term care benefit for disabled persons of all ages;
- coverage of prescription drugs on similar terms for Medicare beneficiaries as for all other Americans; and,
- protection for pre-65 retirees.

The association believes that bipartisan consensus is essential to establishing and maintaining a health care system that works for all Americans. We commend the members of Congress in both parties who have introduced proposals that would achieve universal coverage. It is in all our interests that the solution to a very complex problem reflect the best thinking of Republicans and Democrats alike.

AARP's "Health Care America"

AARP's proposal for comprehensive health care reform, "Health Care America," was developed with the extensive involvement of AARP members across the country. Its centerpiece is universal coverage through a strengthened and expanded Medicare program in which everyone would be eligible for a comprehensive, nationally mandated package of medical and long-term care benefits. Employers would be required to contribute to the cost of their workers' benefits, either through the expanded Medicare program or through private coverage. In addition to ensuring access, the system would foster choice, diversity, and innovation in the delivery of health services. Finally, the system would be accountable to consumers through a new Federal Health Care Commission that would set spending targets and establish other rules.

"Health Care America" reflects the association's commitment to improving the quality of life for all generations—a commitment we believe is shared by President and Mrs. Clinton, members of Congress, and the American people.

AARP Views on the President's Plan

Now that the President's plan is before Congress and the American people, we have shifted our attention to reviewing its many details while using "Health Care America" as a guide. The day after the President's speech, we began a series of field hearings across the country to ask our members what they think. We will continue to analyze the plan in terms of its effect on our members, their families, and the Nation. We will assess its status at each step of the legislative process, and work to improve it. As a start, we have already identified many promising features of the plan as well as some significant concerns.

System-Wide Cost Containment

Rapidly growing health care costs now rob our Nation's economy, businesses, and families of the financial security which we all need to prosper in the future. And many families, including millions of families of older Americans, find it increasingly difficult to even see the future around the mounting health care bills on the kitchen table.

There is much in the President's proposals to curb health care costs with which we agree:

- First, universal coverage must accompany cost controls if they are to be successful. A reform proposal that fails to assure that everyone has coverage will only lead to another vicious round of cost-shifting between payers and providers. With universal coverage, providers will know that they will receive ade-

quate payment for their services. And families will be reassured that they can seek necessary care at the appropriate time without being turned away. Only with the security of universal coverage can we all focus on a more efficient use of health care resources.

• Second, cost containment must be system-wide. We have just witnessed the latest round of Medicare cuts—$56 billion in the 1993 Budget Reconciliation Act. Those cuts will do little to either slow the overall rate of health care cost growth in the economy or provide a long-term solution to the budget deficit. Just like the proverbial squeezing of one end of a balloon, cuts in Medicare-only payments to providers inevitably pop up in higher costs to employers and individuals. And even more troublesome for Medicare beneficiaries, Medicare-only cuts increase the chance that physicians and other providers will not treat them.

In order to contain health care costs in the economy, the President's plan establishes separate mechanisms for limiting public and private health care costs. Limits on public programs such as Medicare and Medicaid would come in the form of specific savings proposals. The new National Health Board and regional alliances would enforce premium limits in the private sector, which would be backed up with a penalty tax on health plans and providers if a limit is breached. AARP believes that these mechanisms—if made to work in concert as part of a system-wide approach—hold significant promise for containing costs. It will be important for Congress to establish the level and phase-in schedule for health spending limits based on the health care needs of Americans, and not based on arbitrary savings-driven targets. It will also be important to achieve an equitable balance between public and private savings.

The President's plan proposes $124 billion in Medicare savings between 1996 and the year 2000. An additional $28 billion of Medicare savings is estimated to result from the requirement that employers pay 80 percent of health care premiums for working Medicare beneficiaries. These reductions come on top of the $56 billion in Medicare savings enacted just 3 months ago in the 1993 Budget Reconciliation Act, the $43 billion in Medicare savings enacted in OBRA'90, and more than $80 billion in cumulative Medicare savings throughout the 1980's. Increasingly, we are hearing from our members that they are paying for these Medicare cuts in reduced access to care.

Controlling health care costs throughout the system must be a central goal of health care reform. Reform must include enforceable limits on private sector health spending, such as premium limits or rate setting, if it is to be credible. The Congressional Budget Office (CBO) recently found that while Medicare spending grew at an annual per-capita rate of 3.1 percent between 1985 and 1991, total U.S. health spending grew at an annual per-capita rate of 4.8 percent. The reason for this difference is that Medicare is controlled through the Federal budget process but private health care spending is not.

Medicare savings will also result from a system-wide approach to cost containment. But the magnitude of the proposed Medicare savings—$124 billion—is alarming on its face. Absent system-wide reforms—and if reductions are unmatched in the private sector—the Medicare program could not sustain such enormous reductions without creating quality and access problems for beneficiaries.

Absent system-wide cost containment, the association will oppose any further efforts to cut Medicare. Moreover, the proposed Medicare savings, even if they can be achieved, are not a broad or permanent financing source for health care reform. Once the system is made more efficient, we will need to identify more lasting funding sources for the public cost of health care delivery.

Financing Health Care Reform—Some Observations

AARP looks forward to an open discussion of the cost and financing estimates of health care legislation. This scrutiny is critical because if proposed savings and revenues do not materialize, then important benefits will be reduced and/or the entire reform effort may be jeopardized. Experience has shown that cost estimates only increase as the legislative process advances.

Experience with the enactment and repeal of the Medicare Catastrophic Coverage Act, in particular, provides this and several other lessons on financing health care reform:

• The American people must view the benefits as comprehensive if they are to be willing to pay for them. Older Americans viewed the new Catastrophic benefits as too meager to warrant widespread support, particularly because long-term care was not included.

- Financing cannot be narrowly imposed on a small segment of the population. Medicare beneficiaries were required to pay 100 percent of the cost of the Catastrophic program, increasing the flat and income-related premiums to extraordinary levels.
- It is unrealistic to front-load the "pain" of financing without a corresponding "gain" in benefits. While most older Americans have shown great patience in their lives, asking them for a full downpayment well in advance of receiving Catastrophic benefits proved unacceptable.
- Effective cost containment is critical to keeping benefits and financing affordable. Due to the lack of effective cost containment, the projected cost of the catastrophic drug benefit (and the resulting estimates of premiums to be paid by beneficiaries) skyrocketed even before the bill made its way through the conference committee.

Medicare: Don't Weaken A Successful and Popular Program

Medicare is the cornerstone of health care coverage for older Americans. Since its inception, Medicare has dramatically increased access to health care for those age 65 and over and the disabled by guaranteeing that coverage is available regardless of health status and by attempting to keep costs for Medicare-covered services affordable. Today, about 35 million Medicare beneficiaries receive important benefits like physician services, hospital care, and home health care.

Medicare's low administrative costs—about 2 percent of program outlays in 1992—help maintain its reputation as one of the more efficient Federal programs. By contrast, administrative costs of private health insurance range from 5.5 percent to 40 percent of benefit costs.

Here, inside the beltway, Medicare is a $150 billion "system" with hundreds of pages of law and regulations. But to the millions of Medicare beneficiaries, it is "my health care plan." And, despite its shortcomings—such as gaps in benefits, lower payment rates, and confusing papervork—it is an enormously successful and popular program, across all age groups.

Our health care system needs comprehensive reform, and Medicare must be part of that reform. Medicare needs improved benefits and access for its beneficiaries. We shouldn't weaken what already works in pursuit of a better overall health system.

Proposals That Reduce Growth in Medicare Provider Payments

There is a widening chasm between what Medicare reimburses and what the private sector pays for hospital and physician care. According to the Physician Payment Review Commission, Medicare now pays physicians on average less than 60 percent of commercial rates. And, according to a recent CBO study, Medicare hospital rates are only 67 percent of private rates. These gaps in payments have resulted in greater cost shifting onto the private sector and less willingness on the part of providers to treat Medicare patients.

The President proposes to further reduce Medicare payment updates for both hospital and physician services, even before the reductions in the Omnibus Budget Reconciliation Act of 1993 (OBRA'93) go into effect. At the same time, payment rates for Medicaid patients and the uninsured will increase to private insurance levels. The critical question for the association is whether the President's private sector cost containment proposals will reduce Medicare-private payment gaps and begin to address Medicare access problems. In the new system, Medicare beneficiaries could become the least profitable patients for providers to treat and experience the same access problems Medicaid patients currently must face.

At this stage, there is not enough information for us to determine what the effect on beneficiary access of the proposed changes will be.

Proposals That Increase Beneficiary Payments

Home Health Coinsurance—The President's proposal calls for a 10 percent coinsurance on home health services. This would create a significant financial hardship for many Medicare beneficiaries, particularly those with low to modest incomes.

For the average home health user, the 10 percent coinsurance would cost about $425 in 1994 alone. For the average user age 85 and older, the coinsurance would cost about $560 in 1994. These increases are on top of the hospital deductible, physician coinsurance, and Part B premium—$2,500 on average—that beneficiaries needing home health care typically face. The proposal also puts physicians who treat the frailest and sickest Medicare beneficiaries in the difficult position of recommending care they know their patients cannot afford.

Lab Test Coinsurance—The new 20 percent coinsurance proposed for lab services will hit hardest on those who already are likely to have high out-of-pocket costs,

particularly those without medigap coverage. Additionally, it would create new paperwork to exchange very small amounts of money on millions of claims. For example, coinsurance would be $2 for a complete blood count. In 1992, Medicare received over 63 million claims from free-standing clinical labs, in addition to those from physician offices and hospitals.

The best way to reduce Medicare spending for lab services is by reducing unnecessary utilization. And the best way to reduce unnecessary utilization is by changing physician and lab behavior. The law virtually eliminating physician self-referral to clinical labs took effect in 1992. Since then, the rate of increase in Medicare payment for lab services has slowed. Additional steps to slow utilization increases might include eliminating payment for those panel tests that physicians do not specifically order.

Establishing a lab coinsurance is not expected to reduce utilization of lab services because beneficiaries play only a very minor role in deciding whether to order tests and which tests to order.

Outpatient Hospital Coinsurance

Beneficiary coinsurance for hospital outpatient surgery, radiology, and diagnostic services far exceeds the standard 20 percent for other Part B services. This occurs because Medicare's payment is based on a blend of hospital and ambulatory surgery center costs and charges while beneficiary insurance is based solely how much a hospital bills for the service. Since the amount a hospital charges is usually higher than what Medicare approves, beneficiaries end up paying considerably more than the 20 percent coinsurance they pay for other Part B services. The Prospective Payment Assessment Commission (ProPAC) estimates that beneficiaries are paying anywhere from 37 to 54 percent in coinsurance. As beneficiaries increasingly receive services in hospital outpatient departments in lieu of inpatient care, the problem is getting worse.

The Administration recognized the outpatient coinsurance inequity and proposed eliminating it in the September 7, 1993, draft of the health care reform proposal. The proposed fix, however, is noticeably absent from the final plan. Instead, the President's "Health Security Act" exacerbates the problem through what has been described as a "technical" change in how the Medicare payment for outpatient services is calculated.

Under the proposal, Medicare would end up paying the Medicare-approved amount for a service minus what the beneficiary pays in coinsurance. For instance, if a hospital charged $300 but Medicare approved only $100, then the beneficiary would pay $60 (20 percent of $300) and Medicare would pay only $40 (which is $100 minus $60). As Medicare pays hospitals less for outpatient services, it puts pressure on hospitals to increase the amount charged to private patients. This results in a cost shift to beneficiaries because beneficiary coinsurance is based on 20 percent of the same hospital charge paid by private patients. As charges go up, beneficiaries will pay more. This vicious cycle won't stop until beneficiaries pay 100 percent of the Medicare-approved amount and Medicare pays nothing.

Income-Related Premium

AARP has strongly opposed increasing the Medicare Part B premium for higher-income beneficiaries outside the context of health care reform. In the absence of comprehensive reform, a high-income premium would constitute nothing more than a cost-shift to beneficiaries without adequate control over system-wide spending.

We also believe that if Part B premiums are income-related, then private-sector premiums should be income-related as well. In 1993 alone, the Federal government will "spend" $48 billion by providing tax breaks for employer-paid health care premiums. This provision is one of the fastest growing tax expenditures in the budget, and is projected to reach $96 billion by the year 2000.

It does not seem fair that taxpayers would continue to subsidize the health care premiums of a Wall Street executive with a salary of more than one million dollars a year while subsidies to Medicare beneficiaries with much lower incomes are substantially reduced. If Congress and the President believe that "income relating" premiums is a good idea for the elderly and disabled, then it is at least as good an idea for the rest of the country—including the Congress itself.

Continued Gaps in Medicare Coverage

We are very pleased that the Health Security Act would eliminate balance billing throughout the entire health care system, including Medicare. Since enactment of physician payment reform, the Medicare program has made great progress in this area; but under a reformed system it will be important to eliminate excess billing for all consumers and enforce this new policy aggressively.

Despite this improvement, however, it is important to keep in mind that while the President's proposal increases Medicare beneficiaries' premiums and cost-sharing, it maintains a high hospital deductible, fails to set limits on total beneficiary out-of-pocket costs, and does not expand currently inadequate low-income protections. As a result, Medicare coverage will be worse than coverage for the under-65 population. We hope that these gaps can be filled as the proposal works its way through Congress. The need for health care, as well as the need for assistance to pay for that care, does not decline when one celebrates his or her 65th birthday.

Additionally, Medicare beneficiaries would pay more for their coverage than individuals under 65. At today's rates, an individual in an alliance would pay about 20 percent of an average $2,000 premium, or $400 per year, while Medicare beneficiaries would pay $583 per year in Part B premiums. Further, to make their benefits comparable with fee-for-service alliance benefits, Medicare beneficiaries would have to pay about $840 additional per year for a Medigap policy, for a total of $1,423 per year just in premiums.

About 10 percent of Medicare beneficiaries are too poor to afford medigap coverage but are not poor enough to qualify for Medicaid or the Qualified Medicare Beneficiary (QMB) program. The QMB program pays Medicare premiums and all Medicare cost-sharing for persons below the poverty level but pays only for Part B premiums for those between 100 and 120 percent of the poverty level (fully implemented in 1995). AARP strongly recommends that health care reform legislation expand QMB protections for low-income Medicare beneficiaries up to 150 percent of the poverty level—to provide protection equivalent to what is provided for other age groups—and make it easier for eligible beneficiaries to apply for QMB protections.

Medicare and Health Alliances

AARP strongly supports the President's intention to retain Medicare as a distinct program rather than dismantle it or force beneficiaries into State-based alliances. There are four fundamental reasons for preserving Medicare as a separate program under the President's plan.

First, as currently proposed, health alliances are not required to provide equal coverage for Medicare beneficiaries. Those who have suggested forcing Medicare beneficiaries into alliances at the outset ignore the fact that older Americans would likely get worse coverage and pay more in premiums than others in the alliance. Until the alliance system can provide equal coverage for older Americans at similar rates, they should not be "folded" into the alliance system. The first step toward integration of Medicare should be to expand Medicare benefits and out-of-pocket protections. At a minimum, the over-65 alliance enrollee should enjoy the same benefit package, cost-sharing, annual out-of-pocket limits, and low-income protections that the under-65 alliance member has.

Second, Medicare can be thought of as its own national health alliance. Under the President's proposal, each health alliance would constitute a separate "risk pool" within which premiums would be community-rated. Medicare has operated in this manner for the past 28 years.

Alliances would allow individuals and their families to choose between fee-for-service and managed care plans. Medicare already allows beneficiaries to choose HMOs or PPOs in areas where they are available. However, there are many areas of the country where such plans are not offered, and, therefore, only 7 percent of Medicare beneficiaries are enrolled in managed care plans. The President proposes expanding Medicare managed care choices and incentives for beneficiary enrollment.

Would also be charged with limiting 6 healthcare premiums and payments to providers—an area in which Medicare has already demonstrated some success.

Third, older Americans are very reluctant to "give up" the Medicare program with which they are very familiar for a new and untested approach. Seniors rely greatly on Medicare for their health care needs, despite the gaps in Medicare coverage. The system functions well for 36 million beneficiaries, but we know little of how the alliances would work.

According to a recent survey conducted by ARRP, 43 percent of respondents age 50 and older oppose the idea of States folding Medicare into their health plans. However, 64 percent of those who do not strongly favor this idea would favor it if they could get substantially better benefits under the State plan.

Fourth, we are not convinced that States would be able to develop and maintain consistent, high standards with respect to the oversight and enforcement that would be necessary to support a takeover of the Medicare program. It will take time and experience for the States and alliances to learn how to run a new system without adding 35 million more people. If Congress decides to grant a limited number of

States the authority to integrate Medicare into broader statewide systems, the association urges that the public be given ample opportunity to review and comment on such waiver requests and that States be required to demonstrate—with thorough Federal validation—not simply "assure," that:

- Medicare beneficiaries will receive the same benefits and protections as the under-65 population; and
- Medicare funds are earmarked so that States cannot divert such funds for other purposes.

Universal Coverage and Comprehensive Benefits

ARRP is very pleased that the President's plan recognizes the importance of universal, comprehensive coverage.

AARP strongly supports the requirement in the President's plan that premiums be community-rated so that individuals under age 65 are neither rewarded nor penalized on the basis of characteristics such as age, gender, or health status. Community rating is the most equitable way to share responsibility and risk across the American population. It is the way insurance should operate, and largely once did in this country. Community rating has important labor market benefits as well, since it substantially reduces disincentives for employers to hire and retain older workers.

Health coverage must not only be available; it must be affordable as well. Individuals alone cannot afford to pay the high cost of premiums, rather it must be a shared responsibility among businesses, individuals, and the government. The President's plan asks all employers—as well as employees—to contribute to the cost of coverage. AARP strongly supports this approach. This mandate would help to level the currently uneven playing field where some businesses—including many small businesses—pay more than their fair share, while others pay nothing. More importantly, employer contributions are critical to achieving universal coverage without substantial increases in Federal income taxes. By requiring individuals to pay something toward their care, the President's plan can reinforce the principle of personal responsibility—a principle already put into practice in the Medicare program through its premiums, copayments, and deductibles.

Many working and non-working families, however, will need assistance in paying their share of premiums, deductibles, and coinsurance. While the plan notes that subsidies would be available to the under-65 population with incomes up to 150 percent of poverty, far more information is needed on the amount of the subsidies at each income level. We are also concerned that low-income Medicare beneficiaries might lose important protections. Currently, over 3.5 million Medicare beneficiaries are dually eligible for Medicaid benefits. An additional one million low-income Medicare beneficiaries are eligible to receive full or partial subsidies for Medicare-related out-of-pocket health costs through the QMB program. It is unclear whether such protections continue under the President's plan. It will be important to assure that these subsidies are maintained and strengthened in a reformed health care system, so that there can be a consistent policy for low-income persons of all ages.

AARP strongly supports a guaranteed comprehensive benefit package for all Americans. In that light, we are deeply disappointed that the President's plan would not provide the same coverage (i.e., the same benefit package, same cost-sharing limits, the same limit on out-of-pocket spending, and full elimination of balance billing) for Medicare beneficiaries as it would for younger populations. We hope that these gaps can be filled as the proposal works its way through Congress. The need for health care, as well as the need for assistance to pay for that care, does not decline when one celebrates his or her 65th birthday.

Long-Term Care

AARP is particularly pleased that the President's proposal includes some coverage for home and community-based care for persons of all ages and incomes. The new program represents a serious though modest start towards addressing the unmet needs of millions of American families. The inclusion of long-term care is vital to our members and critical to AARP's support for any health care reform proposal.

Clearly, Americans of all ages strongly support such inclusion. A survey conducted for AARP this past April found that 90 percent of the respondents felt that including long-term care in a health reform proposal was important. Support for health care reform increased from 46 percent to 82 percent when long-term care was included. More recently, in a poll conducted for AARP less than 2 weeks ago, 86 percent of adults of all ages stated that they would be less in favor of the President's health care proposal if long-term care coverage were not included. And, in a

study conducted last year for AARP by DYG, Inc., the amount that individuals were willing to pay for coverage increased substantially when both home care and nursing home care were included.

Long-term care is an issue that touches all of our lives at some point through family and friends. In our view, it makes no sense to provide protection against an acute illness but leave people vulnerable if they suffer from a chronic problem, especially since the need for these services is so interrelated. Persons with disabilities—of any age—are much higher than average users of medical services and require both kinds of care to meet their complex service needs.

Unfortunately, while approximately 37 million people lack basic medical insurance, virtually all Americans lack protection against long-term care expenses. To achieve true security, savings and quality in our health care system, coverage must not be limited only to the provision of services by a hospital or doctor; long-term care must also be included.

Although AARP is pleased with the proposed expansion of home and community-based services; it is, in effect, a matching grant program to the States. We have questions about how this would work. For example, the reliability of the funding for the program is a concern.

- Would funding be subject to annual appropriation or sequestration?
- Would the program be included under the PAYGO provisions of the Budget Enforcement Act?
- What would happen if the program ran out of money before the end of the fiscal year? Would services to persons currently receiving care simply be cut off?
- Would a requirement for reassessments between fiscal years interrupt the continuity of care?

Another concern of ours is in what role the States will play. It appears that States would have the option of not participating in the long-term care program at all. This could pose serious problems for consumers. Further, it is not clear what the States' financial obligation would be under the proposal. For example, poorer States, or those that do not fare well in the determination of State maintenance of effort, may effect not to establish a program or may postpone participation until much later in the very long phase-in schedule.

Questions also remain regarding the basic structure of the new program. Although AARP generally supports State flexibility and experimentation, we are concerned that the tremendous variation and fragmentation that exists, especially under Medicaid, might persist. State flexibility needs to be balanced by clear Federal standards to require the provision of basic services, to promote efficiency, and to assure that consumers are fully protected. In addition, it appears that States have the option not to participate in the program at all. Such an approach could pose serious problems if poorer States, for example, elected not to establish this program for its most vulnerable citizens.

Additionally, although AARP supports the modest Medicaid improvements and private insurance standards proposed for nursing home care, millions would remain vulnerable to impoverishment due to lack of protection against the enormous cost of a nursing home stay which now averages $30,000 a year.

AARP looks forward to working with members of this Committee and with other members of the Congress to help ensure that long-term care remains an integral part of the health care reform package and that all Americans who suffer from serious chronic and disabling conditions receive the help they need.

Prescription Drugs

We are pleased that the President's health care reform proposal includes a comprehensive outpatient prescription drug benefit for all Americans, including Medicare beneficiaries. AARP is extremely concerned about the lack of access to prescription drugs (an estimated 72 million people do not have coverage), particularly among older Americans. The combined effects of high prices, heavy utilization, and the absence of affordable insurance coverage for prescription drugs have significantly limited access to needed drug therapies for older Americans. A recent national survey sponsored by AARP showed that:

- older Americans use significantly more prescription drugs than other age groups to maintain their health;
- prescription drug insurance coverage declines rapidly as age increases; and
- out-of-pocket costs for prescription drugs are significantly higher for older Americans than for their younger counterparts.

As a result, many older Americans cannot afford high prescription drug prices and are too frequently denied access to essential, often life-saving, medications—compromising their health status and making them more likely to receive unnecessary and more expensive acute care. About 10 percent of those surveyed said they have had to cut back on necessary items, such as food and heating fuel, to afford their medications.

The incorporation of a prescription drug benefit in health care reform will ensure access to important, often life-sustaining, drug therapies to all Americans, especially those who are most vulnerable to losing access today. Lack of a prescription drug benefit today contributes substantially to unnecessary hospital admissions and other conditions that can be prevented or controlled through pharmaceuticals. With more breakthroughs in drug development, medical care in the future will rely increasingly upon drugs and biotechnological products.

We are also pleased that the President's proposal includes strong cost containment mechanisms as an essential part of the Medicare drug benefit. We are concerned, however, that pharmaceutical manufacturers are already engaged in a major lobbying effort to eliminate any meaningful cost containment provisions from the proposed plan. In fact, we understand that the industry's leading association is attempting to scare Medicare beneficiaries into falsely believing that the President's cost containment efforts will result in the absence of Medicare coverage for important breakthrough drug therapies. We do not believe this is true.

In this regard, we strongly encourage the President and the Congress to remain firm in their commitment to contain prescription drug costs under the Medicare drug benefit. If effective cost containment is eliminated from the proposal, the Medicare drug benefit will quickly become unaffordable to both taxpayers and beneficiaries. This was clearly the case during the development of the Medicare Catastrophic Coverage Act (MCCA). Due to the lack of effective cost containment, the projected cost of the MCCA drug benefit (and the resulting estimates of premiums to be paid by beneficiaries) skyrocketed even before the bill made its way through Congress.

The pharmaceutical industry argues that every dollar sought by policymakers to contain drug prices will come directly out of research and development of important breakthrough medications. We believe this is simply false. Much more than legitimate research and development activities go into the manufacturer's price of a drug. Thus, drug manufacturers have many choices as to where they can be more efficient and cut costs.

In fact, according to a recent study by the Senate Special Committee on Aging, only 16 percent of the manufacturer's price of a drug goes toward research and development compared to the 36 percent that goes toward profits, marketing, and advertising. In addition, drug manufacturers' revenue will increase substantially under the President's plan as millions of Americans who currently lack coverage for prescription drugs will gain that coverage. Much of this revenue could be used for legitimate research and development endeavors.

Vulnerable 50-64 Year Olds

About half of AARP's 33 million members are under the age of 65. In listening to these members, we have discovered some disturbing trends. A 1992 study of public attitudes toward health care reform conducted by DYG, Inc., for AARP revealed that the 50-64 year-old population is much more critical of the health system than are other age groups. Not yet eligible for Medicare, this age group is the most concerned about the cost of health care and the security of their coverage. Only about half of 55-64 year olds are in the workforce, and a disproportionate share of those who are employed earn low wages, work in smaller firms and industries least likely to offer coverage, or are self-employed. Gaps in coverage for this age group may also result from retirement or Medicare enrollment of an older spouse, divorce from or death of a working spouse, early retirement for medical reasons, or insurance industry underwriting practices that are increasingly squeezing less healthy individuals out of the group market.

AARP is pleased that the President's plan would provide health security for a segment of this vulnerable population—so-called "early retirees." Such a system for retiree coverage would also help to restore the competitiveness of industries that have previously borne a disproportionate share of retiree health costs. According to the draft proposal, retired workers age 55 to 64 who meet the 40-quarter work requirement would receive a government subsidy for 80 percent of the premium for the nationally guaranteed benefit package. Former employers who now pay retiree health benefits would continue to contribute toward retiree coverage by paying the retiree's 20-percent share of the premium.

While this feature represents a significant improvement, the plan does not offer comparable protections for non-working, vulnerable 55–64 year olds who do not meet the Social Security requirement of 40 quarters of work. It is our understanding that retirees age 55 to 64 who do not meet this requirement would potentially be liable for the entire cost of their health premium in the alliance. This is of particular concern for women in this age group, who may not have the necessary work history but are now widowed or divorced.

A related concern is the plan's restriction of Medicaid coverage for supplemental services to recipients of cash assistance only (i.e., SSI and AFDC recipients). One out of every three current Medicaid recipients age 50 to 64 is eligible on a basis other than cash assistance. Over 20 percent of near-elderly Medicaid recipients do not work and have incomes over 150 percent of poverty, leaving them without either employer contributions or Federal subsidies to help ensure their access to health coverage under the alliances.

Some have suggested that a more straightforward, efficient, and fair way to assuring coverage for the 55–64 year old group is to lower the age of Medicare eligibility to 55. AARP believes that Congress and the President should consider this approach as a possible alternative to the more limited "early retiree" proposal.

Governance, Quality and the Consumer

The President's plan proposes a new system for governing and organizing health care financing and delivery. For most consumers it will mean getting coverage, receiving information about health plans, evaluating quality, and lodging grievances through a new entity called a regional alliance, rather than going through an employer or an insurance company. The plan also proposes to establish a National Health Board at the Federal level that would be responsible for setting national standards, enforcing the national health budget, and overseeing State administration of the new health system. Finally, the proposal gives States important new roles and flexibility in managing a reformed health care system.

We strongly agree with the President that our system for providing coverage and delivering care must be more responsive to consumers. Consumers need to have a say not only in their selection of health plans, but also in governance and assuring quality throughout the health care system.

The association welcomes many of the President's initiatives to improve the quality of care. Because accurate and useful consumer information will be critical to public accountability and choice, we are particularly pleased to see that an extensive consumer information program has been proposed. Among the elements of the new quality program that we applaud are: (1) the use of consumer surveys to measure access to and satisfaction with care, as well as its outcomes; (2) the development of uniform encounter and claims forms, key to a nationally standardized database; and (3) the development of a core set of quality and performance measures.

We must recognize, however, that it will take a long time to develop and implement the data systems which are envisioned, and that many critical performance and quality measures—particularly those which measure the quality of care for persons with chronic physical and mental illnesses are not yet available. We believe that there must be sufficient resources to develop the necessary information and data infrastructures, and that these funding sources should be specified in the proposal.

While consumer information is a critical component in the overall quality assurance strategy, by itself it will not adequately address consumer concerns about the potential for poor quality care. As proposed, the plan does not clearly identify those entities that are to be responsible for protecting consumers from incompetent providers.

In addressing these matters, the roles of State medical licensure boards and insurance regulators need to be carefully articulated. The proposal to eliminate the Medicare Peer Review Organization (PRO) program without a clear successor entity also raises a number of concerns. On the basis of what criteria would the decision that Medicare beneficiaries are adequately protected in the new system be made, and what entity or entities would pick up current PRO functions?

Another important consumer protection is access to independent and timely appeal mechanisms in the event of quality problems or denials of care. While the proposal does note that plans must provide "due process" for patients to appeal denials or reductions in coverage, these protections are not specified, and it appears that it would be left up to the plans to decide how much process is due. AARP believes that there should be nationally uniform due process protections for all consumers.

CONCLUSION

In conclusion, AARP commends the President, as well as the many members of Congress on both sides of the aisle who have brought the issue of health care reform to this stage. The President's plan incorporates many of the features that AARP has supported in its own proposal. At the same time, both the scope of the President's plan and the need for greater clarity on certain key provisions, not least of them financing and the ability to deliver the coverage promised, require careful consideration. ARRP will work with the Congress in a bipartisan way to ensure that comprehensive benefits are guaranteed to Americans of all ages in a final health care plan.

If there's one thing we should all agree on, it's that the status quo is not an acceptable option.

The CHAIRMAN. Cecil, thank you very much. That is a fine statement. Johnnie, welcome, we are glad to have you.

STATEMENT OF JOHNNIE PUGH, STATE CHAIR, ASSOCIATION OF COMMUNITIES ORGANIZED FOR REFORM NOW (ACORN)

Ms. PUGH. Senator Bumpers and members of your Committee, I thank you on behalf of ACORN for inviting us to testify on health care reform, because we are working for all of the concerned citizens. I am State Chair for the Arkansas Community Organization for Reform Now. It is the first affiliate of the Association of Community Organizations for Reform Now which is nationwide, and it is now known as ACORN. We are taking care of all of the lower and moderate income families.

I am a health care provider, I am a licensed practical nurse, and I do work with elderly citizens. I testify before you today as a representative of low and moderate income Americans. We in ACORN would like to see universal coverage and full health security. All Americans should be covered by health insurance. Citizens should be protected from losing their health insurance because of change of jobs, insurance company abuses, or other circumstances.

All Americans should have access to the same comprehensive package and benefits covering all medically necessary care, including preventive care, prescription drugs, and medical health care. All Americans should have protection for long-term care, whether in the home or in the nursing home.

We in ACORN are very pleased to see that the Nation and the Senator is focusing on the needs of comprehensive care for all Americans. It is something that we have been working on for many years. Back in 1978, just across the Mississippi River in Memphis, TN, was the first ACORN convention. During this time, a platform was set up which was called "The People Speak". And during this time, during the platform, we had blueprints. Back 15 years ago, one of the nine planks in this platform was health care, and we headed it with the following, "Health care must be affordable, accessible, of equal quality for all, controlled by the people of the community, and not by the doctors, hospitals, or insurance companies."

We think this platform is as applicable today as it was back in 1978. We are including this in the full text of "The People Speak" in our written testimony. I have the copy of the entire plan of this, if anybody would like one, that we did back in 1978.

The last thing I want to share with the Committee is personal experience that brings the needs for the full comprehensive care

for all Americans down to the life, the day in the life of all of our people.

I had a cousin who lived in Warren, AR, and he was very sick, and he came here to one of the major hospitals. He was sent back home. He went back home and stayed at home several weeks, we brought him back. They kept him this time because he was almost in a diabetic coma. Well, this could have been prevented, because the first thing was because he did not pay his bill. He did not pay his bill, because he was too ill to work. He could not work, he had no money. And he had no money to take care of his sister who was taking care of his feeding him and whatnot during this period of time. So, we feel that these kind of things should be prevented.

Working as a nurse in the emergency room, I have seen people who have come in who were sick enough to be admitted to the hospital, but were sent home because they did not have any insurance. We feel like in this day and time, if we can get universal health care, this thing does not have to happen to our people at this particular time. Senator, please do your duties to enact it, and thank you for being here today.

[The prepared statement of Ms. Pugh follows:]

PREPARED STATEMENT OF JOHNNIE PUGH, ACORN STATE CHAIR

Senator Bumpers and Members of the Committee: Thank you on behalf of ACORN for your invitation to testify on health care reform before your subcommittee, because this is a concern of all citizens. I am Johnnie Pugh, state chair of Arkansas Community Organizations for Reform Now, the founder and first affiliate of the Association of Community Organizations for Reform Now, the nation-wide community organization of low and moderate income families generally known as ACORN. I am also a health care provider, working as a licensed practical nurse with elderly patients.

I testify before you today as a representative of low and moderate income Americans. We in ACORN would like to see universal coverage and full health security. All Americans should be covered by health insurance. Citizens should be protected from losing their coverage due to job changes, insurance company abuses, or other circumstances.

All Americans should have access to the same comprehensive package of benefits covering all medically necessary care including preventive care, prescription drugs, and mental health care. All Americans should also have protection for long term care, whether provided at home or in a nursing home.

We in ACORN are very pleased that the attention of the Nation and of the Senate is now focusing on the need for comprehensive health care for all Americans. It's something that we've been working for for many years. Back in 1978, just across the Mississippi River, in Memphis ACORN groups from around the country gathered for our first national convention at which we began development of the ACORN People's Platform—our blueprint of what America needs. Back 15 years ago, one of the 9 planks of this platform was Health Care and we headed it with the following: Health Care must be:

- Affordable.
- Accessible.
- Of equal quality for all.
- Controlled by the people of the community, not by doctors, hospitals and insurance companies.

We think this platform is as applicable today as it was in 1978. We are including a copy of the full text of our People's Platform Health Care plank to our written testimony.

The last thing I want to share with this Committee is a personal experience that brings the need for full and comprehensive health care for all Americans down to the level of daily life.

I had a cousin from south Arkansas who was turned away from a major hospital here in Little Rock because he had not paid his bill, because he had been too ill to work. Because he did not care when he needed it, several weeks later he became so

ill that he almost went into a diabetic coma, at which point they had to admit him. This should not be allowed to happen in America.

Working as a nurse in emergency rooms, I've seen people who should be admitted sent home because they have no insurance. For this reason, we need universal health care for all citizens.

Senators, please do your duty and enact it.

Thank you.

The CHAIRMAN. Johnnie, thank you. You always speak extremely well for your organization, and I appreciate your taking the time to come down and be with us, too.

Just a couple of questions. Cecil, right now, more than anybody else, the seniors know what they have in Medicare.

Mr. MALONE. Yes.

The CHAIRMAN. And they are very concerned about these questions you just raised, "What if they run out of money? What of this, what of that?" They know that is not going to happen with Medicare. So, at least for the time being, they do not want any part of this plan.

Mr. MALONE. That is correct. That is basically what I am finding. I speak to four and five groups each week, and they come across pretty strong that they are worried because they do not think that this is going to be adequately financed.

The CHAIRMAN. Well, I might also say, that is a very legitimate concern of mine, as it is of anybody who studies it. I hope it will be, but I saw a question in the press a couple of days ago, somebody asked, "What are you going to do if the alliance runs out of money?" They said, "Well, we just have assumed that Congress would appropriate more." You know, Congress hated that S&L bail-out.

Mr. MALONE. Right.

The CHAIRMAN. And nobody wanted to go home and testify or just tell their people, "Yes, I voted for this." Well, it turned out to be about 150 billion instead of 500 billion. You know, we heard all of the big figures about what it was going to cost, and it cost a lot less, but still, nobody relished the idea of going home and saying, "I voted to bail out all of those crooks and defrauders," and so, they just voted, "No."

They did that last year, in 1992, refused to vote another clean-up to finish cleaning up the S&L mess. You know what that lack of political courage cost? $20 million a day, because Congress did not have the courage to say, "We are going to finish this thing up." So, they had to continue buying all of those bad loans on the books, disburse all of the declining value assets. It cost $20 million a day. I might say, and I do not say this in a self-serving way, do you think I enjoyed voting for that?

Mr. MALONE. No.

The CHAIRMAN. Of course, I did not, but I knew that was something that had to be done. So, you cannot depend on Congress if these alliances run out of money. Congress may or may not, it just depends on how the political winds are blowing that day.

Mr. MALONE. And I just——

The CHAIRMAN. Your point is absolutely well taken.

Mr. MALONE. Yeah. I think the older population has the interest that you are talking about. From what I understand, I believe they

would even be interested in paying more tax to make sure that, if you have a system, that it is adequately financed.

The CHAIRMAN. I think, though, Cecil, if we start this program and we get 3 or 4 years under our belts and it seems to be going along very well—I think probably that Medicare is going to become a part of it at some point, just because everybody has to be under it at some point, but they will not be nearly as apprehensive. Right now, they feel like they would be giving up something in the hand for something in the bush.

Mr. MALONE. That is correct.

Others: That is correct.

The CHAIRMAN. They do not want to do that, and that is very understandable. So, politically, it is not doable now, either.

Herb, let me ask you a question, and this has nothing to do very much with what we are here for. But you come out of the ranks of labor, and you are fairly knowledgeable on this, and certainly not the least of the reasons being because you have been in this Seniors Organized for Progress, which has its main thrust, health care for the seniors, but you have been here a good part of the day and have also heard these people testify about small business, and that really is troublesome to me. I do not know what to do about it.

But if the studies show that there are 2 million small businesses in this country, and that probably 300,000 of them are going to have to shut their doors in order to comply with this, what would you do if you were Senator Bumpers?

Mr. BINGAMAN. Well, Senator, as you well know, I spent some 30-odd years at the collective bargaining table and I dealt with many small businesses over the years, and I am talking about plants of 10, 20, 50, 100, 200 people. And in most situations, we were able to develop a health care program for the business, because they really wanted to cover their people. As I understand the President's program, I must modify it with that small businesses are going to be able to put in like 3½ percent, as opposed to discussion of 7 percent for other larger businesses.

Now, I believe that in the long run, the total cost of health care across this country will be much less when we can truly support a health care system for all Americans and stop the cost-shifting. Today, these small businesses, I know they are concerned about it, but what happens is, when their people do not have insurance, then they have to go to the emergency ward in the hospital, or wherever they go, and the cost-shifting takes place, because they cannot afford to pay. Somehow or another, we have to develop a universal health care program that is going to give comprehensive care to everybody.

Further than that, it is my true belief and recognition that, somehow or another, they will find a way to pass that onto us, the consumers, and I know they will have to do that in some final analysis. If they are charging 10 cents for an item, or $10 or $10,000, and eventually, if they are going to have to pay the cost of health insurance for their people, they are going to charge that off as an item of expense for running the business, just like they would for rent or anything else.

The CHAIRMAN. Philosophically, I agree with you totally, but if you are a small businessman out there with 20 employees, and you

are struggling to make it and just barely breaking even, do not tell him to charge it off, because he has nothing charge it off against.

Mr. BINGAMAN. Well, Senator, I know it is a problem. I think it is a problem that we have to find a solution to. And if we do not, then we are going to be fragmenting and leaving in place a fragmented program which will ultimately come back to bite us. I have sympathy for the person who is trying to run the small business, I do not think we want to run 20,000, 30,000, or whatever number, out of business, because we need jobs. People need jobs in this country.

The CHAIRMAN. And it is everything. If people do not have the dignity of a job, they do not have anything.

Mr. BINGAMAN. They do not have anything. With large corporations downsizing the way we are, we really have a serious problem, and have to make sure that small businesses can continue to operate, but there is a solution to that. We just really need to look for it, that is my feeling about it.

The CHAIRMAN. I certainly intend to look, and that is one of the reasons we are here today.

Mr. BINGAMAN. Yes, sir.

The CHAIRMAN. It appears that we are going to have to schedule other hearings. I wish I could wave a wand and all of a sudden it would come clear that, "Here is the solution to this problem." I know that is not going to happen. Another thing that troubles me about the small business part of this problem is that, if you say to somebody, "If you can keep your wages below $12,000, you are in the clover," or "If you can keep your business from growing beyond 75 employees, you are in the clover," what kind of nonsense is this?

Mr. BINGAMAN. I agree. That is a problem, Senator, because we need decent wages. People cannot live on $12,000 a year.

The CHAIRMAN. No. And I will tell you, you will find people paying themselves dividends instead of salaries. They will be doing everything in the world to circumvent the salary level. I am really troubled. I have not talked to Mrs. Clinton about that particular aspect of it, but I am troubled by that.

Mr. BINGAMAN. Yes, sir.

The CHAIRMAN. And you know, one of the problems of Congress, as somebody said awhile ago, "They haven't been to Eudora; they just do not know what the real world is like."

Mr. BINGAMAN. That is right.

The CHAIRMAN. Now, I do not say that self-servingly, because some of them do. There are a lot of people out there who, and I have said many times in the Senate, there are about 40 people out of 100 in the Senate who are extremely bright and motivated persons, they are there for all of the right reasons, trying to leave the country a little better than they found it, trying to take care of people who do not have jobs or health care, all of that sort of thing, you have about 40, you just show them the latest poll, and that is where they are going to vote. You have about 20 that do not know the difference.

I know that sounds almost arrogant on my part to say, but it is the truth. And people oftentimes who go to Eudora do not see it. They can go there, but they leave and they did not really see it.

Mr. BINGAMAN. That is right.

The CHAIRMAN. You know why? Because it does not affect their children, it does not affect them. Well, I guess we could stand here and pat ourselves on the back as being superior to those people all afternoon, but these are real human problems. If you are a breadwinner and you are sitting at the table and looking at a wife and three children, for example, and you are unemployed, can you think of anything worse? You should see someone like that, and I am talking about pretty able people who have lost their jobs. You are talking about these companies downsizing.

Mr. BINGAMAN. I know.

The CHAIRMAN. Thousands and thousands of people are being laid off in the manufacturing field every day.

Well, I appreciate very much, Herb, you, Cecil and Johnnie for coming to express the views of the consumers. I know your hearts are in the right place. All of our hearts are in the right place, and we simply do not know how this is going to come out.

I promise you, I will do my very best to reach some kind of a sensible solution to this that does the least damage to the people who can least afford it and helps the most people who need it most.

With that, we will stand adjourned. Thank you all very much for your participation.

[Thereupon, at 3:30 p.m. the hearing was concluded.]

HEALTH CARE REFORM

THURSDAY, JANUARY 20, 1994

U.S. SENATE,
COMMITTEE ON SMALL BUSINESS,
Jonesboro, AR.

The Committee met, pursuant to notice, at 10 a.m., at the Convocation Center, Arkansas State University, Jonesboro, AR, Hon. Dale Bumpers, Chairman of the Committee, presiding.

OPENING STATEMENT OF HON. DALE BUMPERS, A U.S. SENATOR FROM THE STATE OF ARKANSAS

The CHAIRMAN. I have never offended anybody by starting a hearing early, because that means we will get out earlier. And though we are scheduled to start at 10 a.m., I wonder is David Stanley here? Well, we can go ahead and start with the two witnesses on the first panel.

Before doing that, I have an opening statement that I will insert for the record, but I would like to express a few thoughts about the purpose of the Small Business Committee hearings, both in Washington and in Arkansas. Of course, one of the nice things about being a committee chairman is that you can hold hearings wherever you want to, and I chose Arkansas.

I find these hearings to be more edifying to me than they are to the people who attend and who testify. It goes without saying that what the President and Mrs. Clinton are proposing is mammoth, I guess you could almost describe it as revolutionary change in the way we deliver health care and the way we pay for it in this country.

I think it would be candid and not out of place to say that the enthusiasm for this proposal has been waning, to some extent, in the last three or four months. I think a lot of that, perhaps, is because of the distraction of Whitewater and the President's trip to Europe and so on.

But there is also an increasing apprehension by people about precisely what is going to happen. Is their coverage going to be as good as it has been in the past? Will their access to the system be as good as it has been in the past? Then they keep hearing horror stories, and of course they see these insurance ads on television, which raises their concern. From a small business standpoint, I can tell you that the small business people of this country are very apprehensive, and very understandably apprehensive.

I will just give you some idea of why they are. Based on national averages, employers would pay $1,546 for each single worker without children and $2,480 for each worker with children, whether

married or single. Now, the way this works for small business, if you have a company with fewer than 75 employees, and the average wage in that plant or business is $12,000 or less, the employer would be required to pay three and a half percent of his payroll. And there is a sliding scale on the wage. As the wages go up from $12,000 to $24,000, the amount that employer must pay increases, until it reaches 7.9 percent.

Another question: If you are an employer and you have fewer than 75 employees, then you qualify for these lower rates based on the average salary in the plant. But if you have over 75 employees, it does not make any difference if the average wage in that plant is $12,000 or less. If you have fewer than 75 employees, you are a small business, but if you have more than 75, you are big business. You are not really a big business, but you automatically have to pay 7.9 percent.

When I ran the Charleston Hardware and Furniture Company, and a nursing home and other things, I thought 10 employees was small business. But, according to modern standards about small businesses, you can have up to 500 employees and still be classified by the Small Business Administration as a small business. But my point is this: There are thousands of businesses in this country, for example, who have 75 employees, but say fewer than 200 or fewer than 300, that if they had to cough up 7.9 percent of their payroll for health insurance, many of them would have to make a fast decision on whether to try to do that or to close their doors.

Now, some people say, "These are the same arguments we heard back in the 1930s, when President Roosevelt was championing Social Security," and that is true. At that time it was one percent. Social Security started out with the employer contributing one percent and the employee contributing one percent. Small businesses especially said, "This is going to bankrupt us." So, people like to say, "Well, you know, they said the same thing then; they are crying wolf again."

But I have absolutely no doubt, even though I am presently a cosponsor of the President's bill, that I will be offering amendments to it, and certainly others will be offering a lot of amendments. Incidentally, what I am talking about does not go to the need to have universal coverage in this country. It is absolutely imperative that we do something to cover the roughly 35 million people in this country who have no health care coverage. And it is important that we do away with preexisting conditions.

I use as a personal note, which I probably should not, my own daughter, who was 4-years old when she was diagnosed with a condition and was operated on extensively. It was not a total cure and we were told it was a condition that may recur. I have carried insurance policies on her at least twice in the last 5 years, carried two policies at one time, to make sure that when she changed jobs she did not get caught in that preexisting condition trap, which, if she did, could possibly bankrupt me. I feel that I am a fairly well-off person. Certainly, I am infinitely better off than an awful lot of people in this country. But I know that even when you have coverage, you can almost bankrupt yourself; and if you cannot have coverage you can just almost guarantee that you are going to be bank-

rupt if you have a catastrophic illness. So, we have to do away with the preexisting condition.

We also have to do away with what we call "cherry picking," and that is where a company says, "We will write your insurance again this year, but in order to write this insurance for you for a year we are going to have to triple your premiums, because you have somebody with AIDS or terminal cancer." That has got to go.

Everybody agrees on those things. Then you get down to the question: Can we afford it? Has the President really thought carefully about the cost? Some people say that they have underestimated the cost by a magnitude of two to three times; others say no, the President is right on the mark on what it is going to cost.

The question of: Can you choose your own doctor? Back to my own daughter, our pediatrician in Fort Smith said, "I will never be happy until Brooke sees this doctor in Boston. He is head of the Pediatric Neurology Department at Children's Hospital, and he is head of neurosurgery at Harvard." That was heady stuff for a country lawyer from Charleston, AR, but, you know, we would have done anything to get her there.

If somebody calling himself a gatekeeper at that time had said, "No, you cannot take your daughter to Boston," you know what I would have said. Yet, that is a part of the President's proposal.

Back to small business. Nationally 42 percent of all the workers in this country work in small businesses. In Arkansas, the figure is almost 50 percent. In addition to that, there are roughly 67,000 businesses in Arkansas, and over 62,000 of them are considered small businesses. I point out that some of those 62,000 businesses in Arkansas that are classified "small," without question, would have to close their doors.

So I am concerned about small business, and the purpose of these hearings is to determine what, if anything, I want to do when this bill is presented on the floor of the Senate to make it more palatable to small business. The National Federation of Independent Businesses is intent—and that is by far the biggest small business organization—on killing the bill.

Let me just close by saying that when it comes to health care costs in this country, you and I both know there is something seriously amiss. About 14 cents of every dollar that is spent in this country, goes to health care. Nine percent is the highest of any other nation, so something is wrong for us to be spending that much more on health care. If we do not do anything, by the year 2000 we are going to be spending 18 cents of every dollar.

Today, in Arkansas, a family of four making $30,000 a year will spend 16.7 percent of their total income on health care, on average. You know, I have been in the Senate 19 years. You do not like to say that out loud, because people are so anti-incumbent minded now, and so term-limit minded. But I have been there 19 years, and we have had to deal with a lot of big issues, but we have never had one as complex, and one that is going to be as volatile as health care reform.

Well, those are just some random thoughts. One final point that does not deal with small business, but it deals with Arkansas, and that is: Of all the people in Arkansas who are uninsured, 25 percent of them are children.

There is one other point I want to make, too. One day Mrs. Clinton wanted to come over and speak to members of the Small Business Committee. She wanted it to be private, she did not want the press there, she just wanted me to get all the Small Business Committee members—we have 22 people on the Committee—and they all showed up, of course, for a little lunch with Mrs. Clinton.

You will not believe this, but I had to go through all kinds of hoops to see if our campaign committee could pay for the lunch. You could not pay for it officially. But that is what we spent a lot of our time in Washington doing, just things like that, to see if we could pay for the lunch.

And the First Lady came over, and the first question was from Senator Bennett of Utah, a new senator and a very fine man, but opposed to this plan. And he said, "Mrs. Clinton, if you walk down the street of small town America, the bakery, with 10 employees, has insurance. Across the street, the dry goods store, with 10 employees, has insurance coverage. At the end of the street is the garage with 10 employees, with no coverage. Now, are you going to require the garage man to insure his employees?"

And she said yes. Because the truth of the matter is one of the reasons the bakery and the dry goods store are having a hard time paying their ever-increasing premiums for health care coverage is because they are having to pay for these ten people down at the garage. Those employees are taken care of.

If a guy rolls over a screw driver and gets a slipped disc or whatever you get when you roll over a screw driver on your back, the cost of his treatment can be pretty great, but he gets it. The hospital may bill him, but he does not have the ability to pay. So the cost shifts and the people who are insured are paying higher premiums to take care of those who are not.

It is the same principle with crop insurance. I am Chairman of the Agricultural Appropriations Subcommittee, and for years we have tried to get all farmers to carry crop insurance. It is the only way it will ever work, if all farmers are required to carry it. But we have never been able to do that. As a consequence, only 50 percent of the farmers in this country carry crop insurance.

Then we have this tremendous flood out in the Midwest. Guess what: All the crops are destroyed, and the 50 percent of the people out there who did not have crop insurance, those people got 5 percent less in Federal grants and subsidies and loans. The people who did not have crop insurance got 5 percent less than those who did. Now, you do not have to be a rocket scientist to know that there is no incentive to carry crop insurance when you have a disaster and the government comes in and doles money out to people who did not have crop insurance. And there is a corollary to what we are talking about here.

Well, with that, we are anxious to hear from our witnesses.

We have Mr. L.D. Rose, who is the owner of Pocahontas Aluminum; and James Scurlock, owner, Jonesboro Concrete Pipe. Mr. Rose, since you are first on my list, please proceed.

[The prepared statement of Senator Bumpers follows:]

PREPARED STATEMENT OF SENATOR DALE BUMPERS

Thank you for joining us this morning. I want to thank our witnesses for the time spent preparing their statements, and, more importantly, for sharing their concerns about the problems of health care.

This is the second in a series of hearings I am holding to hear the concerns of small business owners about the impact the various health care plans will have on them and their ability to continue in business. Over the course of these hearings, the Committee will also hear from providers, consumers, and insurers. We cannot evaluate the impact of health care reform on small business, without taking a larger look at the entire system. We need to know how each reform plan would affect ordinary citizens, the States, public health clinics, businesses that currently self-insure, etc., is the definition proposed for small business in the Clinton plan—75 employees—a proper level or should it be higher? Should every citizen have the right to the doctor of his or her choice? Or, should so-called gate-keepers make that decision? Should there be a single-payor system modeled on the Canadian plan? Should those who presently self-insure be allowed to continue even if they have fewer than the proposed 5,000 employees?

There's one thing certain. While 85 percent of the people have health care coverage, and while the vast majority of that 85 percent think our system needs repairing and is entirely too costly, they should not and cannot be asked to give up what they have unless Congress and the President can give them reasonable assurances that what they're getting is going to be better than what they've got.

There are two forces driving the reform effort: The first is the need to provide health security to everyone; not only the 37 million Americans who are uninsured, but also those workers who are currently insured but could lose coverage if they change jobs or suffer a catastrophic illness. The second is the need to control the growth of health care costs. Health care spending has been on a vertical trajectory for the past 25 years and will continue to swamp the Federal budget and consumers' pocketbooks unless we find some way to bring costs under control.

A few statistics illustrate the point about health care costs:

- In 1980, health care spending represented 9 percent of the GDP. By 1992, that number had increased to 14 percent and it is expected to rise to 18 percent by 2000—that means that nearly $1 out of every $5 in our economy will be spent for health care. No other country spends more than 10 percent.
- This year in the U.S. we will spend as much on health care as we spend on the combined costs of all fuel oil, natural gas, electricity, gasoline, transportation, including all new and used car purchases, furniture and other household equipment.
- Health care spending for each worker in America will cost over $7,000 in 1994. Without reform the cost per worker will increase to $12,386, or 25 percent of total compensation.
- Insurance premiums and workers compensation payments by employers have increased over 200 percent after inflation over the past 20 years and, for many small business employers, the cost of coverage is now beyond their means.
- Here in Arkansas, average family health payments increased by 222 percent between 1980 and 1993. Arkansas now ranks third among the States in the percentage of family income that is devoted to health care spending.

The President deserves credit for taking on the difficult task of reforming the system. Next year the Congress will consider proposals with widely different approaches to expanding health coverage and controlling costs. Some would simply provide tax incentives to encourage private coverage; others, notably the Clinton plan, would mandate employers to provide benefits; and some would institute a single-payor national insurance system, similar to Canada's.

I have co-sponsored the President's bill with the clear understanding that it will be amended extensively before final passage. While I support the goals of the Administration's proposal, I also recognize there are a number of ways to achieve those goals. No approach will be painless. Our challenge will be to find the right balance between short-term pain and long-term benefits.

Again, I'd like to thank our witnesses for appearing today. I've asked them to limit their remarks to 5 minutes each, so we can have more time for questions and answers. I recognize that, given the complexity of the health care issue, 5 minutes is woefully inadequate and I appreciate the effort they've taken to prepare their statements.

The President's proposal alone is over 1,300 pages long and four other comprehensive bills were introduced just during this past session. So I don't expect anyone, anywhere, to be a consummate expert on these reform proposals. All of us should

use our deep abiding concern for what's best, not just for us, but for our country and the people of Arkansas. In doing so, we need only use common sense, based on our practical experience, in arriving at our conclusions.

STATEMENT OF L.D. ROSE, OWNER, POCAHONTAS ALUMINUM, POCAHONTAS, AR

Mr. ROSE. Thank you, Senator.

My name is L.D. Rose, and I am the owner of Pocahontas Aluminum Company, a small manufacturing company in Pocahontas, AR. I have approximately 25 employees. I am pleased to be invited to participate in this health care reform hearing, and I must admit that I do not know as much about the planned reform that I need to, but I will become more knowledgeable.

As an employer, I realize the importance of health care to my employees, as well as to myself. First of all, I want as good insurance as I can possibly afford for my family, and I have no reason to suspect that my employees do not want the same. I have for some time provided a group plan that I feel I could afford. It is a very basic policy, with a $300 deductible. I at one time paid my employees' portions of the premium, and if they chose, they could pay for their family's portion.

However, over the years the rates have increased in such amounts that I have only been able to continue to pay the amount that I was paying when it was the total premium. Now the portion we pay is such a small amount of the premium that most of my employees do not participate on our policy or provide insurance for themselves. Out of 25 employees, I now have three people on my group plan.

I know insurance is a very important employee benefit, and I would like to do better, but I have to compete in the marketplace, and manage to make a profit to be able to provide jobs. I am willing to do more, as long as my competitors and I are on a level playing field. I certainly will be glad to do my share, as I have not always been an employer, but I have been an employee, and I know their wishes.

I have not been happy with insurance for some time. I personally feel that most of the problems lie with the insurance companies, and doctors or hospitals. Not that I am against doctors and hospitals, because they do wonderful things. I think the insurance companies do not do enough to hold down their rates, but merely pay hospital and doctor fees without question.

We have all heard or seen outrageous charges, too many tests, or unnecessary treatments. And I could go on and on, on that. I know not every hospital and doctor is wrong, but it has gotten out of hand.

As a small business, I would welcome changes. Although the President's plan is not perfect, we, as a Nation, should be able to reform and come up with a plan that we can all live with. We should all be willing to want everyone to have some sort of health care. We may have to have different levels, but we all need care.

As a rural community that I live in, we are fortunate to have a very good health care provider. They seem to be committed to provide care at the lowest possible price, and we are proud of them. I personally feel that they are better qualified to speak on this sub-

ject than I am, and therefore, I have let them act in my behalf. However, I do appreciate this opportunity to voice my opinions. Thank you.

The CHAIRMAN. Larry, thank you very much. That is an excellent statement. If you will, just stay seated and we will have a little discussion here in just a moment.

Mr. ROSE. OK.

The CHAIRMAN. Mr. Scurlock?

STATEMENT OF JAMES SCURLOCK, OWNER, JONESBORO CONCRETE PIPE, JONESBORO, AR

Mr. SCURLOCK. Senator, I am Jim Scurlock with Jonesboro Concrete Pipe. I am the president of a small manufacturing company that manufactures concrete pipe and related products within a 150 mile radius. We have been in business for a little over 40 years, and have been profitable. About 15 years ago we acquired another facility in Springfield, MO, that does similar work, and both companies have continued to grow. When I was asked to comment about health care problems, and do we have any as a small company, I certainly jumped at the chance to really try to get our message across.

And to give you an example, we have 28 employees here in Jonesboro.

The CHAIRMAN. How many?

Mr. SCURLOCK. Twenty-eight. And health care and health care issues have taken a disproportionate large amount of time of management. Every year we spend literally weeks looking over policies, and trying to re-bid policies to try to get the most cost effective coverage we can, both from health care and also worker's compensation. I group both of them together, both of them are a tremendous drain on our assets.

Jonesboro Concrete Pipe, in 1993, spent over $70,000 for health care coverage, and health care and worker's compensation for 28 employees. And of those 28 employees, only 8 of them are covered under the health plan. Of course, all 28 are covered with worker's compensation, but only 8 of the 28 are covered for health care. During the past 5 years our worker's compensation has tripled.

Initially our concept was: We will assist you with health insurance. We will pay half of the health insurance for our employees, and they will pay the other half. Five years ago we had a policy that was $170 for family coverage. We paid half of that; the employees had a $200 deductible, 80 percent coverage, and $1,000 out-of-pocket expense.

Costs kept increasing, so we kept changing the parameters to something we could afford and something the employees could afford. We increased our coverage from 50 percent to 65 percent. We have changed the deductible from 80/20 payoff to 50/50 payoff.

The CHAIRMAN. Jim, I am not following you on that. What do you mean 80 percent and 50/50?

Mr. SCURLOCK. Well, initially after the deductible was satisfied, the insurance company would pay 80 percent of the costs.

The CHAIRMAN. OK. Now you are down to 50?

Mr. SCURLOCK. Now we are down to 50.

The CHAIRMAN. OK.

Mr. SCURLOCK. The total out-of-pocket expense, the maximum they would have to pay, initially was $1,200; now it is $5,500. So the coverage for the individual has decreased to the point, instead of having 85 to 90 percent of the employees taking it, we are down to 8 out of the 28 employees taking it.

They just do not feel like they are getting the value for the dollar, and they are taking the gamble if they have a major health care problem, that they will be covered somewhere else. As I mentioned, the cost for the family coverage has jumped from $170 a month to $325, even with these reduced insurance coverages.

I have read several synopses of the health plan, and there are two points I would like to make concerning the plan. First of all, it seems that the perception of business is we are very profitable, we can just pass any increase off to business. My personal opinion, any business that is an established business, if it is extremely profitable it will get to the point where there is no extremely profitable business that has been in business for any length of time. So, given that as a norm, the profits are not there to absorb a whole lot of mandated costs.

So that gives us two options. Companies like mine will either pass increased mandated costs on to our customers, or we will go out of business. Depending on the economic environment, the latter could be more feasible; depending, of course, on the costs.

The second point is: As I was reading the plan, it almost frightened me about the level of government that it looks like this plan is going to create. They talk about a National Health Board, dozens of government agencies with the goal of insuring every citizen. Well, with that type of arm of government, the people to administer it, the people to enforce the laws, the cost to maintain the buildings and facilities, and the transportation needs for all those people, I think, in my personal opinion, it would be like throwing gasoline on an open fire. The problem is the cost of health care. We have limited resources to address those costs, and the funds to pay for those extra costs, the extra government would have to come from the same source that is trying to pay for them now.

The plans I have seen have a lot of good cost reduction ideas. Controlling malpractice insurance I think would be a tremendous factor; reducing insurance costs certainly would help; preservation of local health care systems is needed; encouraging health care providers to share assets and not duplicate assets I think would be important.

The government already has in place procedure cost limits or recommended costs. For example, Medicare has a certain policy for an office visit or kidney removal or whatever. That could be incorporated with the plan, where the insurance companies could have a basis of what costs are recommended. But to control those costs and not create another level of government I think is really what the aim should be. I think that health care reform is badly needed and should be vigorously addressed, but I think the direction should be in reducing the medical costs, and not creating new levels of government that would be a financial drain on the already limited sources that are allocated to pay for those costs.

Thank you.

The CHAIRMAN. Jim, thank you very much. How long have you been in this concrete business?

Mr. SCURLOCK. I got out of the army in 1973, and have been in since 1973.

The CHAIRMAN. How are you related to Louise? I think I have asked you that before.

Mr. SCURLOCK. She is my aunt.

The CHAIRMAN. I thought so. Well, you know, I was almost your uncle.

Mr. SCURLOCK. I know.

The CHAIRMAN. She came by to see me not too long ago. I do not know whether you knew that or not. But she just happened to be in Washington and came by the office, and I spent about an hour with her. She indicated that she was glad that I did not become your uncle, incidentally, Jim.

Mr. ROSE. Senator, if I could, I would like to reiterate what Jim mentioned about workman's compensation. The workman's compensation has dearly hurt small businesses. In the last 2 to 3 years my workman's compensation has tripled. I have maintained about the same number of employees, it is just that the companies have pulled out and forced us to be in a pool. For example, the year before last I paid $8,800 in workman's compensation premiums.

The CHAIRMAN. How much?

Mr. ROSE. Eight thousand. Last year my workman's compensation premium amounted to over $24,000. I do not turn in many claims. Most claims that we have are small claims, and we just pay them to keep the rate from going up.

If this health reform goes through and small businesses are required to pay for health insurance, I would certainly hope that that would eliminate workman's compensation. If we are going to have to pay the health insurance for all of our employees, then I see no need for workman's compensation. If they have the insurance to go to a hospital, I see no reason why it should matter whether they are hurt on the job or hurt at home. And I hope that there is some consideration toward that.

The CHAIRMAN. Larry, let me ask you a series of questions. And Jim, you be thinking about it, too. Incidentally, you did not say how many employees you had, Larry.

Mr. ROSE. Yes, sir, I said I had 25.

The CHAIRMAN. I am sorry, I missed that. You have 25, and Jim, you have 28? Now, Larry, your worker's compensation premium is based on payroll? It is a percentage of payroll, is it not?

Mr. ROSE. That is true.

The CHAIRMAN. And you say it has tripled in what period of time?

Mr. ROSE. That is just one factor, Senator.

The CHAIRMAN. The other is experience?

Mr. ROSE. There is an experience modification rate. In the past year I have had some difficulty with that. I kept getting these increases, and I am like Jim, you know, we fight for lower rates, lower premiums. And I had them fax me a copy of my modification experience rate. I wanted to see how they were coming up with this.

What I found was that there was a company in Paragould, AR, that had had some large claims, and they got entered into my account. So they had tried to raise my modification rate from 1.1, which I felt was too high, to 1.94, which was going to put me paying about six times what I had paid before. I finally convinced somebody that those were not my claims. But I question that if it happened once, how many times has it happened?

The CHAIRMAN. Yeah. Larry, right now, just as a percentage of payroll, what is your workman's compensation costing you? As a percentage of payroll?

Mr. ROSE. Senator, I am going to say somewhere around 8 to 10 percent.

The CHAIRMAN. Eight to ten percent?

Mr. ROSE. Yes, sir.

The CHAIRMAN. Jim, how about you?

Mr. SCURLOCK. Well, I do not have those numbers. In fact, last week I looked at a typical payroll period. We had a gross payroll of $10,600; and of that, $850 was for worker's compensation.

The CHAIRMAN. Do you have any idea how they break that down between health care coverage and permanent benefits? You get all your medical, but also you draw so much a week, and then you have a permanent disability, you get so much for that.

Mr. ROSE. No, sir, I do not. I think that is set by the state legislature. Is that right, Jim? I am not too sure on that.

Of course, Arkansas has made some improvements in the workman's compensation in the past year. My problem——

The CHAIRMAN. This is not an Arkansas problem.

Mr. ROSE. I understand that.

The CHAIRMAN. This is a national problem. The other Senators tell me that their states are just being crucified with workman's compensation increases.

Mr. ROSE. I think we are just catching up with some of the states.

The CHAIRMAN. Yes.

Mr. ROSE. But the problem we have had in the past is, the employer had the burden of proof. An employee could come in and say, "Well, I got hurt a couple of days ago," and there was not anything you could do about it. When an employee is hurt, we are supposed to fill out a claim form immediately.

In one instance, I had a young gentleman that came in and said he was not feeling well and wanted to go to the doctor, and when he come back he told me that the doctor said he had a hernia and needed an operation, and he got the hernia at work. There was not anything I could do about it.

The CHAIRMAN. Yes.

Mr. ROSE. I expected the workman's compensation division to investigate that; they did not. They just paid it.

The CHAIRMAN. That is kind of like unemployment compensation; if you want that taken care of, you have to do it, yourself.

Mr. ROSE. That is right.

The CHAIRMAN. The other question I wanted to ask you was, Jim, without asking you what your average payroll is per employee in your plant, what percentage of your payroll are you paying for just those 8 people, do you know the answer to that? I do not mean

your total payroll. But if you took the payroll of those 8 people, and you counted what you are paying for their health care coverage, your part of it, how much do you pay, 50 percent?

Mr. SCURLOCK. Sixty-five now.

The CHAIRMAN. Sixty-five?

Mr. SCURLOCK. Yes.

The CHAIRMAN. What percentage of their salaries, their wages is that?

Mr. SCURLOCK. We had a $10,600 payroll, and they paid their portion, and we paid $430 in addition to that, so it would be around 5 percent, I guess.

The CHAIRMAN. Your share would be around 5 percent?

Mr. SCURLOCK. Yes.

The CHAIRMAN. Now, you see, under the proposal of the President, you would pay 80 percent and the employee would pay 20.

Mr. SCURLOCK. Yes, sir, but we are only covering 8 of the 28. And right now the policy——

The CHAIRMAN. Wait a minute. Now, was your total payroll $10,000?

Mr. SCURLOCK. Yes.

The CHAIRMAN. You are not talking about just those 8 people?

Mr. SCURLOCK. No, no.

The CHAIRMAN. Your total payroll is $8,000, and you paid $400 just for those 8?

Mr. SCURLOCK. Right.

The CHAIRMAN. Well, those 3 probably only represented about maybe $2,000 of your total payroll, did they not?

Mr. SCURLOCK. Yes, sir.

The CHAIRMAN. And you paid $400 and something on that?

Mr. SCURLOCK. Yes, sir.

The CHAIRMAN. That is a very high percentage, Jim. You might be better off with this coverage.

Mr. SCURLOCK. Well, not if I add the other 20 people to that coverage.

The CHAIRMAN. Yes, that is true, too.

Mr. SCURLOCK. And with the policy the way it is, the way I read it, taking people that have retired and on Medicare and disabled, our insurance company—right now we have a couple of dependents that the insurance companies would not pick up at this point. Now, if they were mandated to pick it up——

The CHAIRMAN. Yeah. You heard me talk about that "cherry picking" awhile ago, and preexisting conditions. That is one of the things that I feel very strongly about on this bill. There is a little bit of good news.

I wanted to bring this up, and you brought it up before I could, and I appreciate that, and that is regarding worker's compensation. What is the breakdown on your cost of worker's compensation for health coverage, and how much for disability?

Mr. ROSE. I do not have that information.

The CHAIRMAN. Well, my point is, this, the President's bill covers that part of worker's compensation that deals with health care. So, your premiums could conceivably go down 50 percent. You know, they never do, but they probably ought to.

My guess is that probably half of your premium has gone for health care. But there is that little piece of good news, that you would not have to pay as much for worker's compensation.

The guy who says he has a ruptured disc and winds up having surgery, has got a $20,000 doctor bill. That would be covered under this proposal. So that would save something.

Mr. SCURLOCK. Senator, part of the problem with worker's compensation is the lack——

The CHAIRMAN. Policing the claims?

Mr. SCURLOCK. Yes, sir. We had two people in the last 20 years that I am aware of who were about ready to retire, and got a $15,000 and a $30,000 settlement for worker's compensation and both of them——

The CHAIRMAN. How much?

Mr. SCURLOCK. Fifteen thousand and $30,000, and both of them were arthritis related. There is a strong incentive for the medical community to blame anything they can to work related injuries because they get 100 percent coverage, and there are almost no questions asked.

The CHAIRMAN. Jim, you mentioned passing on costs.

Well, let me ask each one of you this question first. If this bill were in effect right now, where would you come out on how much you would have to pay? Somewhere between 3½ percent and 7.9. Do you know the answer to that?

Let me give you the scale, and maybe you can find it in this. If you consider anything I ask to be proprietary information, do not hesitate to say so.

But if your wages in your plant are less than $12,000, your premium will be 3½ percent of payroll; if it is $12,000 to $15,000, it is 4.4 percent; if it is $15,000 to $18,000, 5.3 percent; and as I said, it goes on up. When you get up to $24,000 or more, your premium is 7.9 percent. Now, I assume that both of you would be paying something maybe more than 3½, but less than 7.9 percent.

Mr. ROSE. Is that an average payroll?

The CHAIRMAN. Average payroll.

Mr. ROSE. Or is it based on each employee?

The CHAIRMAN. No, that is an average for the whole plant. If you had 25 employees, and the average of all those employees—some of them make more than others, obviously—but if the average——

Am I right on this?

Ms. CHAFFEE. Yes.

The CHAIRMAN. We will say the average is $15,000. You would have to pay 5.3 percent.

Mr. ROSE. I would say that my company would probably fall in the 5.3 percent category.

The CHAIRMAN. That is about where you would fall?

Mr. ROSE. Yes, sir.

The CHAIRMAN. Jim?

Mr. SCURLOCK. Probably a little more.

The CHAIRMAN. Yes.

UNIDENTIFIED. Excuse me, would you say that one more time? If you have 40 employees, and you take all the salaries?

The CHAIRMAN. They were saying that their contribution, under this formula, would probably be around 5.3 percent.

Now, Jim, the next question I wanted to ask was: You said this cost would just have to be passed on. In your concrete pipe business, how easy would that be to do?

Not everybody, but an awful lot of people are going to be in the same boat as you. And if that is the case, you could probably do it. But if you are competing against some big companies who are already carrying this kind of insurance, you would have a more difficult time doing it, would you not?

Mr. SCURLOCK. Yes, sir.

The CHAIRMAN. What do you think your ability to pass these costs on would be in your industry?

Mr. SCURLOCK. Probably we could pass it on without a whole lot of effect.

The CHAIRMAN. What about you, Larry?

Mr. ROSE. I think, as long as everybody else had to have it, I could pass it on, too. Of course, eventually it is coming right back to the consumer.

The CHAIRMAN. It is going to be a little bit inflationary, then, is it not?

Mr. ROSE. Yes, sir, it is. One of my questions is: Will we be paying for just the employee portion, or is this going to be a family plan?

The CHAIRMAN. Well, this has to be a family plan, as I understand it. Everybody in the family would be covered.

Mr. ROSE. OK.

The CHAIRMAN. Right now, particularly the self-employed people, the companies who self-employ only cover the employee and not the family.

Mr. ROSE. Well, I have several employees, out of my 25, who has a spouse that works for another company that is paying for their insurance.

The CHAIRMAN. Has her coverage?

Mr. ROSE. So, when I say I have 25 employees, and only 3 have coverage, that is a little bit misleading because, like I say, some of them do have insurance with their spouse. But I do have probably 50 percent of my employees that just cannot afford the insurance.

The CHAIRMAN. Yes.

Mr. ROSE. They live on a farm.

The CHAIRMAN. Staff tells me that each employer would have to pay on their employee.

Let us assume you have a husband and wife working, and let us assume that there are four children in the family. Now, how would that work?

Ms. CHAFFEE. Each employer would pay.

The CHAIRMAN. For two children? Would each one have to pay the family plan?

Ms. CHAFFEE. Yes.

Mr. ROSE. OK. Most of the time it does not make any difference whether you have five kids or one child, it is a family. So I assume, in this case, both would be paying the family plan, based on what Mary Ann tells me. Will the rates be based on age?

The CHAIRMAN. On age?

Mr. ROSE. Yes, sir. My present plan, the rates change as age changes. For example, mine starts out with under 30, and then it goes from 30 to 39.

The CHAIRMAN. As far as I know, age is not a factor in this plan.

Mr. ROSE. OK.

The CHAIRMAN. I think that this is something we will cover when some of the doctors testify a little bit later. But you have a basic package. And, incidentally, the doctors in the audience can be thinking about this, because one of the things I want to ask is: What should be included in a basic package? Or maybe more easily: What should be excluded from the basic package? Obviously, elective surgery would be one of the things you would want to exclude from it.

I guess somebody in Washington, a board appointed by the President, is going to determine what the basic coverage will be. Now, that basic coverage is going to be something less than a lot of these blue chip plans that float around right now.

It is not going to cover face lifts or hair transplants and that kind of thing. It is going to cover things that are not necessarily elective, that people are entitled to have. But it is going to be a bare bones policy, and presumably will cost considerably less than most of the plans cover now.

But there is not going to be any distinction between sick people and well people, and there is not going to be any distinction between children and adults. It is going to be a basic package. I think you will find this as a matter of interest, but what happens is, they will say, "We have concluded that this bare bones package ought to cost this amount of money. Now, Prudential, Metropolitan, Blue Cross-Blue Shield, if you people want to insure people on this basis, here is what it is going to cost." Then they say yes or no. Do you follow me on that?

Mr. ROSE. Yes, sir.

The CHAIRMAN. That is a simplified version of it, but that is the way I understand it so far.

Mr. ROSE. OK, I have another question on——

Of course, I live in a small town, and there are very few doctors there, but——

The CHAIRMAN. Incidentally, I broke ground for your hospital, and then came back a year later and dedicated it.

Mr. ROSE. Yes, sir.

The CHAIRMAN. I think you were there both times, Larry.

Mr. ROSE. I certainly was. We each have what we call a family physician. If this plan goes through and we have this kind of insurance, will my people be able to go to their own private, personal physicians, or will they just have to go to a hospital emergency room?

The CHAIRMAN. Under the present plan, these doctors will sort of sign up to say, "I want to be included in this." And if you had 10 doctors in Pocahontas, and half of them were signed up and half of them were not, your people would more or less be required to go to the ones that were.

Because what happens is, in order for the alliance to determine what this package ought to cost, they have a set of fees. In other words, if you are going to have a heart bypass, that will be sched-

uled at some price. Everything is going to be scheduled at a price. These doctors, then, sign up and say, "Okay, I am willing to work for those fees." Is that a fair statement?

Ms. CHAFFEE. Yes.

Mr. ROSE. Well, they tell me they do that now.

The CHAIRMAN. She knows more about this than anybody in Washington, and I have to turn to her all the time, because it really is a complex issue. But that is essentially the way it is.

So, to answer your question, Larry, I suspect everybody in a town like Pocahontas, would sign up and say, "Okay, we will do that."

Today, some people will not take Medicare patients. What is called "taking assignment." They will not do it. And if you are a Medicare patient, you have got to find somebody that will take you. Or cough up the extra part. Now, they will say, "We will take you, but you are getting billed for the extra 20 percent, and we expect you to pay it." You cannot do that, legally, anymore, can you?

Ms. CHAFFEE. You cannot be "balance billed," right.

The CHAIRMAN. I was wrong about that. But a lot of people will not take Medicare patients because they just do not want to mess with the paperwork. There are not too many, but some doctors do not.

But the question about doctors of your choice is a very volatile issue. When you tell people I cannot go to Dr. Jones over here, who delivered their children and who has treated them for colds and the flu and everything else, they are going to get very upset.

I will tell you all an interesting story. We had an old doctor in my home town. He has been dead many years, so I guess I can afford to tell the story. I think he went to medical school for only 6 months. But anyway, three women moved in there from Chicago, and they were all very intelligent women. I met this one woman who said, "You know, if I ever get sick, do not take me to Dr. Jones, just let me die naturally."

Mr. STANLEY. Senator?

The CHAIRMAN. Yes. David?

Mr. STANLEY. We are supposed to be right there.

The CHAIRMAN. You sure are. Come on over.

Mr. STANLEY. We are running late.

The CHAIRMAN. That is quite all right.

Mr. STANLEY. This is my wife, Penny. And I am going to let her sit in the chair.

The CHAIRMAN. Now, there is a guy who has been trained well. Go ahead, pull that microphone over to you.

We are pleased you could make it. We were about to give up on you.

Mrs. STANLEY. Well, we are here.

Mr. STANLEY. I looked around the corner and saw my name on there, and I said——

The CHAIRMAN. Is it true you are Duke Marr's uncle?

Mrs. STANLEY. I am his aunt.

The CHAIRMAN. You are his aunt?

Mrs. STANLEY. Right.

The CHAIRMAN. There is quite a difference there, is it not?

Mrs. STANLEY. Right. That is why I get the microphone.

The CHAIRMAN. We got into this aunt and uncle thing awhile ago. Please proceed, Penny.

Mrs. STANLEY. The ice kind of slowed us down a little bit. There is a lot of ice between here and Augusta.

STATEMENT OF PENNY AND DAVID STANLEY, FARMERS, AUGUSTA, AR

Mrs. STANLEY. We are farmers. I am the business end of the farming operation, so I handle the payroll; and David handles all the other stuff, all the dirty work and all the actual talking to the employees. But I am the one who writes that check every week.

The main thing that frightens me about an additional cost to us is the wedge that it is going to further drive between employers and employees. An employer's mind set is on that gross pay. We know what we spend every year, whether it is for Social Security taxes, unemployment, FUTA-SUTA— what our withholding is. We are very aware of that gross paycheck.

An employee, on the other hand, is only aware of that net paycheck, especially in our industry. Now, you have got to realize that in the farming industry you have a special type employee, and you have a declining rural population. Therefore, you have a declining employee base.

We have employees that look very closely at that net paycheck. We have employees that are well able to afford, if it were a priority with them, to insure themselves. They are not insufficiently paid; it is just simply not a priority in their lives. This is due to several factors. But our fear is just this further antagonistic state of affairs that we could have between the employer and the employee.

Everybody certainly needs health care. I would not consider not having health care. But I am a different type person.

I heard the gentleman say just a minute ago that one of the things that would happen with the cost is that possibly the cost would be passed on. In the farming industry we do not have a place to pass the cost on. You have to remember that the Federal Government already manipulates us pretty well. One of David's good friends told him one time that, "Hey, man, this is a puppet show, and they pull the strings." And to a——

UNIDENTIFIED. They do everybody.

Mrs. STANLEY. —to a degree that is very true.

Our costs or our prices, due to government programs, are manipulated to keep farm prices or commodity prices at a minimum, so grocery store prices do not skyrocket. We provide the food for the country, and it is very necessary to keep us in business for that reason.

But, while we are being manipulated on the one hand to keep prices right for the supermarket and to keep an oversupply—that is what they—what it appears that we need in this country, is an oversupply, so that we never run short—we have no way to pass this cost on to a middleman or to the retailer. And that is one of our greatest fears.

The CHAIRMAN. Well, Penny, that point is really well taken. I used to say this in jest, but there is a certain seriousness to it when I was governor—I used to come over to East Arkansas and tell the

farmers that they were not getting enough for their product, and then go over to West Arkansas and tell the cattleman and the chicken farmers that grain prices were too high. That is sort of the box people are in all the time in this country, one way or the other.

But I must say I have been really comforted to see rice prices in the $11 to $12 range just simply because Japan is going to buy 2 million tons of rice. And, 2 million tons of rice is just a little over 1 percent of the world's production, it does not amount to anything. But there was a psychological impact there to cause rice prices to just skyrocket. That really bodes extremely well for rice farmers in our state. That is a big cash crop.

If rice farmers knew that that $11 and $12 price would hold up, oh, it would be Joyville. But we do not have any way of knowing what it is going to be from one day to the next.

But, having said that, how many employees do you have, Penny?

Mrs. STANLEY. We have actually two different farming operations: one, a fish farming operation, and one a row crop. And it depends on the time of year, of course.

The CHAIRMAN. Yes, it is all seasonal.

Mrs. STANLEY. Anywhere from 10 to 20, you know. We are not a big operation.

The CHAIRMAN. How many fish ponds do you have?

Mrs. STANLEY. Twenty-seven.

Mr. STANLEY. We have about 420 acres of water. Catfish, mostly, but some bait fish.

The CHAIRMAN. How many employees do you normally have there at the fish farm?

Mrs. STANLEY. At the fish farm? Four to five.

The CHAIRMAN. I wondered, as I flew into Little Rock yesterday afternoon and everything was frozen over—this has nothing to do with what we are here for—I wondered, do you have to break the ice on those ponds in this kind of weather?

Mr. STANLEY. It is advisable. You get a lot of gasses. There is constant biodegradation or whatever going on in the pond. If you do not get the ice layer off, the gasses will build up in the water.

The CHAIRMAN. Yes.

Mr. STANLEY. Most people either try to run a well or light a paddle wheel aeration, try to keep an open area. So, it is not good if you do not keep it open.

The CHAIRMAN. Yes. How many acres do you have that you row crop?

Mrs. STANLEY. About 6,000.

The CHAIRMAN. And how many employees do you have in one season?

Mrs. STANLEY. You will be shocked. This year we averaged, with 6,000 acres, about 6 employees.

The CHAIRMAN. Six?

Mrs. STANLEY. And part of the reason is because of the high cost. We like for our employers to have a decent style of living. So, the pay scale is commensurate with that. When you start tacking on all the other things that we are required to pay, then, by necessity, we have to keep our workforce low.

The frightening thing about tacking on something else, is how many more employees we are going to have to do without, how

much more mechanization we are going to have to go to because tractors and combines do not have to have health insurance——

The CHAIRMAN. Penny, do you carry health insurance on your employees?

Mrs. STANLEY. No. Years ago, when I first took over the books, it was offered to them. David offered to take out a group policy and pay a percentage and deduct a percentage. They took a vote at that time, and no one wanted it. They did not want anything deducted from their pay. They did not want the responsibility of it.

This is something else that scares me about a Federal program. So many of our Federal programs have enabled people to shirk responsibility, not through lack of intelligence, but it is an enabling factor. They do not have to be responsible for themselves or their families. Therefore, they let the government take care of it. We do not offer health insurance, and we have not offered it in several years, because it was turned down.

The CHAIRMAN. Do you have any employees on a year-round basis?

Mrs. STANLEY. Yes.

The CHAIRMAN. How many do you have on a year-round basis?

Mrs. STANLEY. Five to six.

The CHAIRMAN. Five to six?

Mrs. STANLEY. And I say year-round. Usually for about 3 weeks during the winter they are actually drawing unemployment. But other than that, I would say year-round.

The CHAIRMAN. Would their salaries average less than $15,000 a year?

Mrs. STANLEY. No, they would average more.

The CHAIRMAN. More than that?

Mrs. STANLEY. Yes.

Mr. STANLEY. In excess of $20,000.

The CHAIRMAN. In excess of $20,000? Well, you are familiar with that sliding scale, then, are you not? That you pay 3½ percent if it is $12,000 or less, and it goes on up to $24,000?

Mrs. STANLEY. Right.

The CHAIRMAN. Do they make more than $24,000?

Mrs. STANLEY. Not all of them. Some of them, yes.

The CHAIRMAN. Well, you would probably be up in the——

Mrs. STANLEY. We would be close to the 6 or 7 percent range, I am sure.

The CHAIRMAN. Yes. It is like you said, you cannot pass your costs on. Some could, some could not. What is your opinion about what the impact of this would be? Would you have to hang it up or——

Mrs. STANLEY. No, of course we would not have to hang it up. Our employees expect a raise pretty annually. And they usually get it. That would have to cease for awhile. I mean, in effect, the employees would have to absorb the costs in one way or another, or we would have to do with fewer employees.

The CHAIRMAN. What do your employees do when they get sick?

Mrs. STANLEY. We have a few whose wives work in——

The CHAIRMAN. Where they cover the family?

Mrs. STANLEY. Right, where they cover the family. And some of them actually just have major medical bills out there hanging over their heads.

The CHAIRMAN. Would it be fair to say that if this bill passed in its present form—which is not even close to being likely; but in any event, let us assume that it did, would it be fair to say that your employees would simply have to forego the annual kinds of pay increases they have come to expect, in exchange for health care coverage?

Mrs. STANLEY. Probably or annual bonuses that they expect. There is usually a bonus at the end of the year, and there is usually a raise. They could lose both.

The CHAIRMAN. Are those bonuses based on a formula, or are they just based on how well you do?

Mrs. STANLEY. They are based on the year.

The CHAIRMAN. You all sort of arbitrarily decide whether you can pay a bonus or not?

Mrs. STANLEY. Sure.

The CHAIRMAN. Would it be fair to say, then, that, assuming that you could pass these increases on to the employees by simply saying, "We are going to spend this on health care coverage, but you do not get a raise this year," you could not do that?

Mrs. STANLEY. We could do that, but what I am telling you is that they would resent it.

One of the biggest problems with farm labor is the rate of turnover. There is already a lot of resentment in the farm community as far as the labor situation goes. In the rural areas, especially in my particular area, there are a lot of people who are not working at all; they are on welfare or other Federal programs.

The people who are working for us are seeing their net pay—the chunk that taxes already take out of their pay. I mean, they are paying a tremendous load in taxes. They are seeing people a mile down the road from them on welfare, whose style of living is not really a whole lot worse than theirs.

And, you know, here they are working very hard. Farm labor is extremely hard. And not doing a lot better. I am saying that you start pulling more away from them, they are going to be glad they have health care coverage when it comes time to go to the doctor. But when they see that net payroll or when they see that check in December that does not have a major bonus attached to it, they are going to be resentful, and they are going to blame David Stanley. They are going to start looking for another employer. We will have another turnover.

The CHAIRMAN. Well, Penny, I must say, I have been in public life more years than I like to admit, and I have spent a lot of time with farmers, and I have spent a lot of time on their farms. And your pay rate is the highest for farm labor I have ever heard anything about. I applaud you for that. I think that is very commendable. You obviously have very good employees, and you are obviously very happy with them, and they are happy with you.

Mr. STANLEY. They work a lot of hours.

The CHAIRMAN. I am sure they do. I mean, there is no such thing as overtime on a farm.

Mrs. STANLEY. Right.

The CHAIRMAN. But, anyway, you are to be commended to pay the kinds of wages you say you pay.

Mrs. STANLEY. They earn it.

The CHAIRMAN. And I bet you do not have much turnover, do you?

Mrs. STANLEY. We do have turnover. Yes, we do.

The CHAIRMAN. Do you?

Mrs. STANLEY. That is what is so frustrating. Yes, even in our situation. Now, we have a little core of people who have been with us for several years, but we have a lot of turnover. We have a lot of unemployment claims—I am constantly writing a letter saying, "Wait a minute," you know, "this person walked off the job."

The CHAIRMAN. Listen, I used to write a lot of those.

I had two businesses, and I do not want to be terribly, shall I say, pejorative about this, but I would say 50 percent of the employees in the businesses I was involved in, some of them came to work——

For example, in a nursing home we had about 50 employees. It was not uncommon for people to come in and work for 2 weeks, and then go allege a back injury or something like that. Some of it was legitimate. It is very difficult to know who is legitimate and who is not in these cases. We know there is a lot of malingering that does happen. Larry?

Mr. ROSE. I have one more concern, Senator, about the health insurance program. I have some friends who are self-employed, and they have maybe three or four employees. This gentleman I know had a heart attack. Shortly thereafter his wife developed cancer. I do not recall exactly what their premium is right now, but it is somewhere over $10,000 a year that they are having to pay just to maintain an insurance policy.

How will this affect Jim and me as business owners, if we have an employee who has a heart attack. Like you mentioned earlier on, that if someone had a large claim that caused all of our rates to go up right now, and I know my policy does.

The CHAIRMAN. That would not happen under this plan.

Mr. ROSE. It would not happen?

The CHAIRMAN. It would not. If everybody in your place came down with AIDS or cancer, it would not increase your premium a nickel.

Mr. ROSE. I would say that would be one good point.

Ms. STANLEY. That is one of the major points.

The CHAIRMAN. I must say that is probably the best point in the whole thing.

UNIDENTIFIED. Who pays for it?

The CHAIRMAN. Well, those people who do not have AIDS.

Mr. ROSE. One other thing I would like to say on something that Mrs. Stanley said. And I have some employees that cannot afford to have insurance. And what I see happens is that they go to our local hospital, at the emergency room, and the hospital has to absorb those fees. Now, in all—when it all comes back around, like she said, the government is going to take care of that.

The CHAIRMAN. Well, do you know what has happened?

Mr. ROSE. I am sure our hospital administrator, Mr. McBride, is going to testify after awhile, and he will probably elaborate on that

more. But that is one thing, the government is already paying a large portion of this thing, because——

The CHAIRMAN. I do not know what percentage they pay, but 17 percent of the Federal budget goes for health care.

That is the reason the President keeps talking about how you will never get the deficit under control until you get health care costs under control, because that and interest on the debt are the two fastest growing things in the budget.

Mr. ROSE. Well, my point on that was, for an example, if I have someone who is working for me who is under 30 years old, a single person's policy is $99.82. Of that, I pay $41.09. Well, they do not want to pay that extra money a month, and they just say, "We are not going to have insurance. If we get sick, we will go to the hospital. They have got to take me in."

The CHAIRMAN. In the future he will not have any choice about whether he participates or not.

Mr. ROSE. OK.

Mr. SCURLOCK. Senator, I think it is real important on the level of participation. When I was on active duty, a lot of friends of mine were doctors. And since it was totally free for dependents, they were inundated by people coming in and making appointments for almost nothing but visits. CHAMPUS, the military program—I do not know if it is still in effect, but——

The CHAIRMAN. Yes.

Mr. SCURLOCK. —where everybody pays a percentage, 20 percent or 10 percent or whatever it is, and they can go wherever they want in a non-military facility, the usage is way down. When we start giving free coverage for everybody, there is going to be a great deal of waste that would not be there if everybody was paying a percentage or a fair share.

The CHAIRMAN. Jim, let me tell you something, though. And this is not necessarily countering what you are saying, because I essentially agree with what you are saying. But there is another thing in this bill that I do like. And that is, it covers a lot of preventive health.

I have said many times if I died tomorrow, the country would owe Betty Bumpers a much bigger debt of gratitude than they will ever owe me, because she has saved millions and millions of man and woman hours, parents whose children did not have polio and did not have measles and did not have mumps because of her efforts. She has been in Atlanta, down at the Centers for Disease Control the last few days—well, I am not going to get into that.

It is simply to say: Immunization of our children is the biggest payback, from a preventive health care standpoint, of anything else. A lot of people do not like the WIC program, because it is essentially for poor, pregnant women. A lot of people say, "Well, they are shiftless women," all that sort of thing. That may be true.

Seventy-two percent of all the black babies being born in this country right now—do not misunderstand me, this has nothing to do with race, but I will say that the time has come when you cannot be politically correct by acting like these things do not exist. They do exist, and until we start talking about them we are not going to deal with them. Seventy-two percent of the black babies of this country are born out of wedlock.

And the numbers among white women are climbing faster now than they are among black women. In 1992, 300,000 of these children were black; 900,000 of them were white.

But, getting back to the point of preventive health care, I think that is one of the best things about this bill. Hubert Humphrey used to get up on the Senate floor, when I first went to the Senate, and he said, "We talk about national health insurance; we ought to call it national sick insurance. It is worth nothing until you get sick."

The Ford Motor Company has shown conclusively, and other employers have, too, that if your employees have a physical every year—and you can negotiate a price for that, make it practically nothing. Sam Walton wanted to do that. I had a long talk with him one time about how he would like for all of his employees to have a physical every year, because he thought that would be the best way in the world to keep his health care costs down.

And you are going to be able to do a lot of that under this plan. I mean, like mammograms and blood pressure tests, all those things, annually. That is where you can save a bucket of money, with preventive health care.

But I was about to talk about these WIC children. You can say, "Well, she got pregnant and she should not have, and that is her third child," and so on. Incidentally, I am going to get deeply involved in that problem, too, because that has gone on much too long.

But if you let a pregnant woman go for 9 months with no prenatal health care—John Eason runs the clinic in Marianna, and he will verify everything I am telling you, from just common, practical sense. You let her go with no prenatal care, and you let her go without worrying whether she has a good protein diet, chances are you will get to spend $2 million on a defective baby for the rest of its life. So you just shoot yourself in the foot when you take a hard stance on that and say, "Well, she should not have gotten pregnant."

I say she should not have gotten pregnant, either. And these AFDC payments are also skyrocketing. Medicaid is skyrocketing. Well, that is a slightly separate subject. That is welfare reform, and believe it or not, we have that issue coming up, too, this year.

Do any of you have anything else you would like to add to what has been said? Let me do two things: No. 1, specifically thank each of you for coming here this morning in this bad weather, to be with us and testify and tell us about your individual experiences. They are very helpful to us.

Second, I neglected to thank Arkansas State University for the use of this facility and helping staff set this up so we could hold this hearing this morning. I want to specifically thank them. Thank you again for coming this morning.

Mr. ROSE. Thank you, Senator.

Mrs. STANLEY. Thank you.

The CHAIRMAN. Our second panel consists of Dr. Robert Yates, obstetrician and gynecologist, Northeast Arkansas Women's Clinic in Jonesboro; Dr. M.A. McDaniel, family practitioner from Helena; and Mike McBride, administrator, Randolph County Medical Center in Pocahontas. Dr. Yates, your name is first on my list, so

please proceed. I want to thank each one of you for taking the time to come and be with us this morning.

Let me make one other observation, that is: Even though this is technically a Small Business Committee hearing, it would not be worth much if we did not hear from providers and a few other people who are going to be dramatically affected by this, one way or the other, adversely or favorably. But, Dr. Yates, thank you very much for being with us, and please proceed.

STATEMENT OF ROBERT YATES, M.D., OBSTETRICS-GYNECOLOGIST, NORTHEAST ARKANAS WOMEN'S CLINIC, P.A., JONESBORO, AR

Dr. YATES. Senator, I am pleased and concerned to know that the government is dealing with the complex issue of health care reform. I have been a physician in private practice in Jonesboro for 10 years. I started in 1984, opened my own practice, and fortunately my practice has grown quite rapidly. We are an obstetrician-gynecologist group with six physicians. We deliver over 1,000 babies a year.

During that time, we have also run two small businesses. One is my medical practice. We have 20 employees. Our health care cost costs us $100,000 a year. As best we can determine, if the plan goes through they will go to $160,000 a year. My income during that time has not increased.

The CHAIRMAN. Now, is that for 20 employees, Dr. Yates?

Dr. YATES. Yes. We provide health care for our employees.

The CHAIRMAN. That is $5,000 per employee?

Dr. YATES. Yes. Our physicians' families get total coverage; our individual employees get individual benefits, and then they can elect to include the family at their expense. So we pay for the employee. They can deduct from their salary to pay for family coverage, which some choose to do and some do not.

When I first started, I was receiving $800 to deliver a baby. And I am quoting insurance prices right now. I now receive roughly $1,600. My income has stayed the same. I will pay tax on the same dollars. So in 10 years, with doubling our fees, income has not changed. Certainly I make a good income, but obviously the money is not coming to me.

During this time we have seen many changes in health care. The technology, the things we can do, the diseases we can treat, the cures we can do have all uniformly improved. At the same time, insurance has sort of gone the other way.

When I first entered practice, if a patient had insurance all we had to do was verify that it was in effect, that it had the proper waiting time, and the claim was paid. We now have legitimate claims that are denied, and the only recourse of the patient is to seek legal counsel to try to recoup the funding.

This relates to: Sometimes there was a waiting period that was not explained properly, or, as one patient recently had a very fine print clause, went into the hospital, had surgery, thought they were going to pay, the insurance company said, "You did not read the fine print," and they did not pay. So now they have got a $5,000 bill. This is the part that I want to see us deal with and

change—this is the part that I and my patients need to see improved.

COBRA law has been a major drain on obstetricians-gynecologists. We are essentially indentured servants to patients that receive no prenatal care, they come to the emergency room, and we have to see them, treat them, and take care of them, when they assume no responsibility for coming and obtaining prenatal care. A lot of these patients are just looking to sue us if they get a bad baby, and their bad baby is a result of their poor participation.

We are not allowed to transfer this patient to a more appropriate facility that is capable of providing them with better care. Certainly we do not want to dump on the university hospital or the teaching hospital, but I feel that this is one of the ways we can save costs.

The Medicaid program has skyrocketed. We see patients all the time that either have insurance and also get Medicaid, or that are perfectly capable of paying their bills, but get Medicaid.

At the same time, we have developed a health care system that I feel is as good as the world has ever seen. We treat diseases that used to be fatal, life expectancy has gone up, we are able to provide a great range of health care. We have done this with a system that is not cost effective. We are looking for the one-in-a-million cause, but if that is you, then you want us to find that and pick it up and cure it. That costs money.

We are now being faced with cutting back, as we had a discussion in our office the other day, a test we routinely do, that we have only seen positive once in 10 years, but that saved that baby's life. Now, if that is your baby, do you want us to do that test and find that? Sure. How do we pay for it?

I have been in many meetings and many discussions recently with other physicians on: How do we do this? But obviously we recognize that there is a problem with cost. We hear that every day. How can we help contain this?

When I first entered medicine, as a medical student, as a resident, I provided a lot of health care. I provided health care to a lot of indigent patients. Sometimes I was closely supervised, sometimes I was not. But the times that I provided health care, I felt I provided high quality care. I was interested, I was concerned, I was wanting to read about this routine disease, and to know everything there was to know about it, as opposed to some other doctor that maybe had been in practice, like me, 20 years, who that is the millionth time you have seen it, and you are not as interested.

We have health departments, we have VA hospitals, we have a public health service. That these kind of institutions, if they are involved and built into a true health care system with access to all people, is a way to control costs.

We have an empty military hospital at Blytheville. I worked at that hospital. That is a fine hospital. If it was staffed with doctors and nurses, it could provide care to these people.

We feel, on the providers' side, that the way to provide quality care and maintain cost is to develop some kind of system, and it has got to be a two-tier system. Insurance cannot pay for everybody. But at the same time, we can provide care to these people if we will develop a system.

And that is the thing I like about the President's plan. I do like the health care board, I like the people that are being talked about. I think Dr. Elders has done a good job. I think she is controversial, but, as you said, she addresses the problems. The ex-surgeon general I think is an excellent man. I think if we have these kind of quality people leading a health care system, then we can figure out how to pay for it.

But I think we need to involve our medical students, our VA hospitals, our military hospitals, and things that are currently existing to provide that system.

The CHAIRMAN. Is that the conclusion of your testimony, Dr. Yates?

Dr. YATES. Yes, sir.

The CHAIRMAN. Dr. McDaniel?

[The prepared statement of Dr. Yates follows:]

PREPARED STATEMENT OF ROBERT L. YATES, M.D.

I am pleased and concerned to know that our government is dealing with the complex issues of health care reform. I have been a physician in private practice for 10 years since 1984. I opened my own practice at that time and we have grown to a private practice of obstetrician/gynecologists with six physicians that deliver 1,000 babies a year.

During this time I have seen many changes in the health care system. The changes in technology and the care that we are able to render our patients, the diseases that are now treatable that weren't, and the diagnostic tests that are available have all uniformly improved. On the other hand, the access to the health care system and the financing of health care have become much more complicated and much more difficult for me and my patients.

When I first entered practice, if a patient had insurance, then we would automatically assume it would pay if the waiting time limit had been met and if the patient was eligible. Now many times patients who have legitimate claims are denied reimbursement and have no other recourse except to seek legal assistance to recoup the money that is legitimately owed them. Many other times patients have legitimate claims denied because the policy was explained to them inadequately by their insurance representative who failed to inform them of exclusions or waiting periods. Many people are at a point where they cannot obtain insurance due to pre-existing conditions and/or the cost is so great they cannot afford it.

Physicians have become essentially indentured servants to a COBRA law that forces us to care for patients who assume no responsibility for their own health care and are ready to sue us at a moment's notice. We have seen our insurance practice decline due to increased enrollment in the Medicaid program of patients who appear perfectly capable of paying for their health care bills. So a change is needed and change is inevitable. Dealing with these problems is the exciting part of the health care reform that is being discussed between the White House and Congress.

At the same time I am quite concerned. We have developed the best health care that the world has seen to this time. We are being forced to choose options that will decrease the quality of that health care to make it become cost effective. It is a shame that in the twentieth century going into the twenty-first century we have to accept compromise on the quality of health care due to our inability or our unwillingness to finance it.

In discussing this with other physicians, it is our feeling that by increased utilization of medical schools, teaching hospitals and VA hospitals we can provide quality medicine and not compromise the quality of care but we would be able to decrease the cost and provide wider access. Patients desire to maintain their freedom of choice to choose their hospital and choose their doctor. I feel this is a basic right that should be maintained for people who are footing the bill for their health care, whether by private insurance or through a contribution to a government program.

Insurance companies, the government and business need to decrease the cost of health care so that we can remain competitive in the global economy. Unfortunately, human beings only have two assets, time and money and we spend our time and convert it to money. If a person is unable to work because they are not healthy, then the country has no wealth. Our greatest resources are people that are capable

of working, producing and contributing to a viable economy. If our Nation is not physically healthy, then we have nothing.

Our legal system has to be reformed to contribute to the cure and not continue to be a part of the problem. Bad doctors, nurses and hospitals need to be appropriately punished, whether it be for poor quality of care or gouging the system monetarily. The costs are run up by defensive medicine created by unnecessary litigation on all levels.

I would hope that the ultimate solution would consist of a true health care system, not a hodgepodge of patched up systems as we currently have. That this system would consist of a government entity that assumed overall supervisory regulatory control to make sure that the quality of medicine was great and that the cost was the least possible. Paper work and governmental regulations should be decreased instead of increased, and that support could be obtained where necessary, both monetarily and through information systems. I feel that this definitely needs to involve the current existing government hospitals, VA hospitals, military hospitals, state and national health departments and the National Institute of Health. I concur with the present plan for a National Health Board with strong input from the Surgeon General.

As far as financing goes, I feel that we need to maintain a private insurance system and that we need to make this system practical and viable by alleviating the burden of non-paying patients from the system. I think the insurance process needs to be streamlined to where the patient either has insurance or does not and that the insurance pays for all medical problems and the patient knows he/she is covered for anything that is necessary.

To provide quality of health care to all Americans and to give the security that the President has so aptly stated that all Americans deserve and need, I feel a second tiered system consisting of a government administered health program is absolutely necessary that provides a basic package of benefits that provide high quality health care but does not provide excessive benefits such as private rooms and certain high costs for non-essential items such as cosmetic surgery for non-reconstructive purposes and other items that could be cut without decreasing the overall quality.

To be cost effective and not increase taxes greatly, this system needs to consist of a system that utilizes medical schools, medical students, nursing students and other areas of medical technology such as dentistry and x-ray technology. Students provide quality care and can help provide a basic package of care to all Americans. This system can be developed to provide a basic network of hospitals where this care can be received within easy driving distance of all communities in the country. This system should utilize existing hospitals where available and new hospitals be built only where necessary. This system would begin with a series of clinics that would move up the ladder to regional medical centers usually at university teaching hospitals.

We can hopefully develop the greatest health care system the world has ever seen with the coming changes. We absolutely must not compromise the quality that we have obtained.

ROBERT L. YATES, M.D., F.A.C.O.B.,
Northeast Arkansas Women's Clinic, P.A.

STATEMENT OF MARION A. McDANIEL, M.D. FAMILY PRACTITIONER, HELENA, AR

Dr. MCDANIEL. Senator Bumpers, I am Dr. M.A. McDaniel from Helena, AR, and I appreciate the opportunity you have given me to come and speak. I misunderstood Mr. Argon when he gave me a note on what to present, and I am presenting mainly aspects of how we treat patients in Phillips County. I think we have a unique situation down there.

I represent the Helena Regional Medical Center in my community, Helena and West Helena. I would like to give you a little insight on the Mississippi delta area, which is part of the county I represent.

Helena Regional Medical Center is a private, not-for-profit corporation, with an 18 member board. We have about 155 beds licensed,

of which we only operate 100, and most of the time we have less than an active census of 50 patients. We have a medical staff which consists of 20 dedicated doctors, and all of which, as you addressed a minute ago, accept assignment. This is a necessary thing in our community.

We are kind of locked into a triangular area by the Mississippi River on one side, and the White River on another side, where people are forced to use our hospital as a primary care center. Our nearest competitors are Clarksdale, MS, which is about 35 miles from Helena; Memphis hospitals; Little Rock hospitals; and Baptist in Forrest City, all of which require the patients to go a long way, if you live in north Desha County, to get any type of medical care.

From the health care status statistics for Lee, Phillips, and Monroe County in the 1990 census, we service a population of about 53,000 people. There are approximately 26 people per square mile; the minority population in this area of our market is about 51 percent.

The percentage of residents below the poverty level is about 42 percent, and in Arkansas it is about 19 percent. Thirty-two percent of this population is under 18; the three-county area per capita income is less than $7,000. We have a teenage pregnancy rate of about 25.3 percent, probably one of the largest in the United States.

The CHAIRMAN. Dr. McDaniel, let me stop you just a moment, now.

Dr. MCDANIEL. Yes, sir.

The CHAIRMAN. That teenage pregnancy rate is interesting to me. You say the teenage pregnancy birthrate of 25.3 percent——

Dr. MCDANIEL. Of the teenage students in our area. This is out of the census. I assume it would be the ratio of teenagers to teenage pregnancy.

The CHAIRMAN. To all births?

Dr. MCDANIEL. To all teenagers.

The CHAIRMAN. Well, are you saying of all births?

Dr. MCDANIEL. I mean, I got this out of the census, and that is what it said, and I did not bring the book.

The CHAIRMAN. Well, that is OK.

Dr. MCDANIEL. I would assume it was a ratio of teenagers to the teenagers being pregnant, and, if I was assuming what I am saying is correct, that would include all teenage girls, not teenage boys.

The CHAIRMAN. It is a high rate, any way you slice it.

Dr. MCDANIEL. Sir, I deliver them. I am telling you, it is a high rate. Until we got a new doctor here, I was delivering 450 babies a year by myself, out of necessity, because we could not attract an obstetrician. I have known Dr. Yates for several years, more than I would like to admit right here. But we have got a unique situation in our county.

Comparing, by rank, the average income of the other 75 counties in this state, the counties we service, Monroe County ranks 71st; Phillips County ranks 74th, and Lee County ranks 75th. I think, without a doubt, we are the poorest service area in the state of Arkansas.

In our area, I would like you to know that our doctors and hospital take care of all the patients who come into our hospital. We do

not refuse medical care to anybody. Our staff and our hospital take on all patients, whether they have income, insurance, or no income.

There is no alternative in our area. I have already indicated our hospital's competition area is Clarksdale, Memphis, Little Rock. One thing that I need to point out, we have lost 4 hospitals in our area just by the changes in health reform. They have closed 4 hospitals located in Brinkley, Marianna, Tunica, and Shelby, MS, which is our service area. This area of the Mississippi delta is one of the poorest regions in the United States.

The report of the Lower Mississippi Delta Development Commission is ample proof of the condition in our delta area. There is no doubt we need some type of medical reform, and our area and doctors do support health reform as presented by President Clinton.

But I feel at the present time our rural communities need to be paid attention to and not left out of health reform. I think we serve a very vital function within our community and within our state, and small rural hospitals have a place, and I hope they are not left out of the reform.

One thing that was brought out by our administrator is, currently our hospital is paid a disproportionate share amount of money from—by Medicare and Medicaid.

The CHAIRMAN. Dr. McDaniel, when you say "disproportionate," you mean more? You get more per child under Medicare?

Dr. MCDANIEL. No, sir, we get less.

The CHAIRMAN. You get less?

Dr. MCDANIEL. I will point that out in just a second.

The CHAIRMAN. OK.

Dr. MCDANIEL. Under President Clinton's reform plan, this will be eliminated, and will be used to help finance his new health plan. I have given you two forms of our disproportionate share as documentation. Our accountants have prepared a Medicaid cost report for 1992. Our auditors indicated that our Medicare disproportionate share adjustment was over $554,000.

I have also provided a letter from the Arkansas Department of Human Services dated June 14, 1993, that indicates our money received for this disproportionate share amount in 1992 was only $132,000. There is quite a difference in the adjustment. Actually, if President Clinton's health plan is approved, our hospital stands to lose over $687,000 in this disproportionate type pay.

The problem right now that I see with President Clinton's health care plan is the new health alliances are going to have to be successful from Day One, and that is not going to happen.

The Medicare program is not integrated into the health care reform except for payment deductions to help finance the new plan. Medicaid and Medicare currently do not pay their fair share, and deeper payment cuts will only hurt our hospital and the doctors in our area, and any other hospitals that have a disproportionate share of Medicare and Medicaid population funds.

Providers will all have different incentives, and I hope one of the incentives is to encourage young primary care doctors to come to our rural care areas and perform their services, and be more enticed to come to our areas. Primary care physicians and specialists in our area are all willing to work with nurses and midwives, but

we should not have a two-tier system in medical care. In essence, the poor being taken care of by nurse practitioners and midwives, and the rest of the people being taken care of by doctors. There should be better incentives for doctors to come practice in these areas.

Phillips County is classified as a health professional shortage area, and Medicare Part B providers do receive a 10 percent increase in medical care payments. However, this does not apply to Medicaid patients. We should have good incentive plans which will include additional reimbursement to some of these young doctors coming back to repay loans which they have incurred during their training.

It is also noted that payment cuts in Medicare and Medicaid play a role in financing the plan that President Clinton has proposed, and these cuts could threaten the viability of our program, and destabilize our whole program here in our community.

There are other conclusions that we have come up with. Medicare must be incorporated into the health care reform, and eliminate plan financing via the Medicare and Medicaid cuts.

We also ask that a deletion in geographic reclassification of our wage index from our urban to rural, or even to the proposed nearest next-neighbor concept. These will be dangerous for our hospital, and the patients we serve.

I would like your assistance in getting the urban Memphis rate reinstated in October for our hospital area. If we do not get this reinstated, our hospital stands to lose, just from Medicare reimbursement alone, about $742,000.

I believe rural health care is economical, and the charges in rural areas tends to be much lower than urban areas. I appreciate your letting me represent our hospital as well as our doctors, because if we do not have a hospital these doctors are going to just go by the wayside. We are not going to have doctors for primary care in our area if there is not a hospital there.

The CHAIRMAN. Dr. McDaniel, that is an excellent statement. Let me say, first of all, that you have my undying gratitude for your work. I do not want to interrupt the proceeding at this point to talk about that, but I bet I spent 50 percent of the time while I was governor trying to figure out how to get primary health care to every area of the state, and especially in the delta. And, you know, I am still spending an awful lot of my time doing the same thing.

Dr. MCDANIEL. Yes, you are, sir, and I appreciate it.

The CHAIRMAN. And people like you and Dr. Jackson over in Eudora, who testified at a hearing in Little Rock, do you know him?

Dr. MCDANIEL. No, sir.

The CHAIRMAN. I think he delivered 400 to 600 babies last year over there, and he is the only doctor in town.

Mike? Please proceed.

[The prepared statement of Dr. McDaniel follows:]

PREPARED STATEMENT OF DR. MARION A. MCDANIEL

Senator Bumpers, I am Dr. M.A. McDaniel from Helena, AR. I would like to thank you for the opportunity for allowing me to represent my hospital, Helena Re-

gional Medical Center, and my community to give you an insight on the Mississippi Delta area which my county is a part of.

As a little insight, Helena Regional Medical Center is a private, not for profit corporation, with a 18 member board. It's licensed for 155 beds, but operates 100 beds with an average daily census of less than 50. We have a medical staff which consists of 20 active members. We have a very unique situation in our general area. We are geographically locked into a triangular area by the Mississippi River on one side, and the White River on the other which confines our population to requiring medical care at our facility, the Helena Regional Medical Center.

From the health care status statistics for Phillips, Lee, and Monroe counties in the 1990 census we service a census population of 53,334. There is approximately 26 people per square mile, the minority population in this area, of our market, is about 51 percent. In Arkansas, according to these same statistics the population is 17 percent minority. The percentage of residents living below the poverty level is 42 percent in our market area, and according to these same statistics for Arkansas, it's 19 percent. Thirty-two percent of this population is under 18 years of age, and the three county average per capita income is approximately $6,954. Persons over 25 years of ago completing high school is about 50 percent, and we have a teenage pregnancy birth rate of 25.3 percent, probably one of the largest in the United States. The rank of average family income for the state's 75 counties—Monroe County ranked 71st, Phillips County ranked 74th, and Lee County ranked 75th, noting that our market area is the poorest in the State of Arkansas.

In our area I would like you to know that we take care of all patients that come into our hospital. We don't refuse anyone medical care. Our staff and our hospital take on all patients whether they have income or no income. There is no alternative care in our local area. Other hospitals we compete with are Clarksdale, MS; Little Rock hospitals; Memphis hospitals; and Baptist Hospital in Forrest City. We have 4 area hospitals which are considered in our market area that have closed. These being Brinkley and Marianna, Arkansas, Tunica, Mississippi and Shelby, Mississippi.

This area of the Mississippi Delta is one of the poorest regions in the United States. The report of the lower Mississippi Delta Development Commission is ample proof of the condition in our delta area. There is no doubt that we need some type of medical care reform. We do support health care reform as presented by President Clinton. But I feel that at present the rural community needs to be paid attention to and not left out of health reform. I feel like we serve a very vital function within our state, within our community and probably within the United States. Small rural hospitals have a place. These hospitals are required to keep the same quality of care and level of care that the major hospitals do.

Currently, we are paid a disproportionate share amount of money by Medicare and Medicaid. However, under President Clinton's reform plan this will be eliminated and will be used to help finance his new health plan. I have given you two forms regarding our disproportionate share payments. One represents our Medicare cost report for 1992. Our auditors report that our Medicare disproportionate share adjustment was $554,650. I've also provided a letter from the Arkansas Department of Human Services dated, June 14, 1993, that indicates the amount of money that we received for our disproportionate share payment for 1992 was only $132,894.62 which is quite a bit of difference between what was indicated on our share adjustment and what we were actually reimbursed. The total amount of $687,544.62 will be a reduction in cash payments to our hospital if President Clinton's health plan is approved.

The problems at this time with President Clinton's health plan is that the plan requires the new health alliances to be a success from day 1. The Medicare program is not integrated into health reform, except for payment deductions to finance the new plan. Medicare and Medicaid currently do not pay their fair share, and plans deeper payment cuts which will hurt hospitals and physicians in our area. Especially those communities where the Medicare/Medicaid population is disproportionate to the rest of the State. Providers will continue to have different incentive systems. We hope that there will be an incentive plan to encourage young primary care physicians to come to our rural areas in the form of incentives. The primary care physicians and specialists in our area are willing to work with nurse practitioners and nurse mid-wives but we should not have a two-tier system of medical care in that the poor are treated by the nurse practitioners and nurse mid-wives, and the rest will be taken care of by doctors. There should be better incentives for doctors to practice in a rural setting. Phillips County is classified as a health professional shortage area and part B providers do receive a 10 percent increase in Medicare payments, but this does not apply to Medicaid patients. We should have a good in-

centive plan which should include additional reimbursements in loan pay back provisions. It also should be noted that large payment cuts in Medicare and Medicaid play a major role in financing the plan. These cut backs could threaten the viability of the program and de-stabilize this entire system in our community.

A unique problem developed while I was preparing to come speak to you. Our hospital received a letter from LeBonheur Children's Medical System dated December 28, 1993. Because of diminished reimbursement LeBonheur Children's Medical Center is forced to require referring hospitals to pay for transport services. This is a problem for our hospital. I have provided a copy also of our emergency room statistics indicating how patients are transported by our hospital to the tertiary centers which provide services our hospital cannot provide at times. As you can see indicated by our report, we did not have any transports to LeBonheur Hospital by their helicopter service. However, this service is setting a precedence if rural hospitals will be required to provide the cost of transport for all of these patients our hospital will be at a financial risk for transporting patients to larger hospitals in urban areas. We have had over 200 transports by ambulance and other helicopter services to hospitals within the state.

There are other conclusions that we have come up with. Medicare must be incorporated into the health care reform, and eliminate plan financing via the Medicare and Medicaid cuts. Also, we would ask that the deletion of geographic reclassification of our wage index from uban to rural or even to the proposed "nearest neighbor concept" will be disastrous for the Helena Regional Medical Center and the patients we serve. We ask you to assist us in having the urban Memphis rate be reinstated as of October 1994, period. If it is not reinstated we estimate that our Medicare reimbursement will drop $742,239. These changes would jeopardize the future of Helena Regional Medical Center, and also jeopardize the loss of other rural hospitals I am sure within our state.

Rural health care is economical. The charges per discharge in the rural states tend to be much lower than in urban areas. And I am proud that I represent the Helena Regional Medical Center, and hopefully we will not allow rural health care facilities to disappear. I hope these facts are helpful to enable you to understand the difficulties in delivering and financing health care services in the eastern Arkansas Mississippi Delta. We need your help. Thank you.

ARKANSAS DEPARTMENT OF HUMAN SERVICES,
P.O. BOX 1437, LITTLE ROCK, AR 72203-1437,
June 14, 1993.

Helena Hospital,
P.O. Box 788,
Helena, AR 72342-9726

Provider No. 103701105

Dear Administrator: We have determined that your hospital is eligible to receive a disproportionate share payment for 1992. This was based on your hospital's unaudited cost report for fiscal year ending 1991.

A tentative settlement is being issued in the amount of $132,894.62 for your disproportionate share payment. This payment will be reflected on your remittance advice. A final settlement payment or recoupment will be made at a later date after we have calculated disproportionate share payments based on audit/desk reviewed cost report information and statistics.

Should you have any questions, please feel free to contact Marilyn Strickland, Manager, Provider Reimbursement Unit at (501) 682-8320.

Sincerely,

RAY HANLEY,
Assistant Director, Office of Medical Services.

From Medicare Cost Report 1992

ERNST & YOUNG - microKOSTPAK SYSTEM VERSION 12
HELENA HOSPITAL

PROVIDER NO. : 04-0005
COMPONENT NO.: 04-0005

RUN DATE: 04-26-1993
FROM-TO : 01/01/92 - 12/31/92
MKP VERSION 12.05

CALCULATION OF REIMBURSEMENT SETTLEMENT
[illegible]ITED IN LIEU OF HCFA-2552-92
[illegible]EET E, PART A

AMENDED

TITLE XVIII, HOSPITAL

PART A - INPATIENT HOSPITAL SERVICES UNDER PPS

		DRG Amount
1.	Other than Outlier Payments	5539349
2.	Outlier Payments	7154
3.	Indirect Medical Education Adjustment	0
4.	Disproportionate Share Adjustment	554650
5.	Additional Payment for High Percentage of ESRD Beneficiary Discharges (See Instructions)	0
6.	Subtotal (Sum of lines 1 through 5)	6101153
7.	Hospital Specific Payments	4127735
8.	Total Payment for Inpatient Operating Costs	6101153
9.	Payment for Inpatient Program Capital (From Worksheet L, Part I, II, or III)	533015
0.	Exception Payment for Inpatient Program Capital (From Worksheet L, Part IV, Line 13)	0
1.	Direct Graduate Medical Education Payment (From Supp. Worksheet E-3, Part IV)	0
2.	Net Organ Acquisition Cost	0
3.	Cost of Teaching Physicians	0
4.	Routine Service Other Pass Through Costs	0
5.	[illegible]illary Service Other Pass Through Costs	0
6.	[illegible]l (Sum of amounts on lines 8 through 15)	6634168
7.	Primary Payer Payments	1662
8.	Total Amount Payable for Program Beneficiaries	6632506
9.	Deductibles Billed to Program Beneficiaries	722381
0.	Coinsurance Billed to Program Beneficiaries	23777
1.	Reimbursable Bad Debts	127186
2.	Subtotal (Line 18 plus line 21 minus lines 19 and 20)	6813534
3.	Recovery of unreimbursed cost under the lesser of reasonable costs of customary charges	0
4.	Recovery of excess depreciation resulting from provider termination or a decrease in Program utilization	0
5.	Other Adjustments (See instructions) Specify	0
6.	Amounts applicable to prior cost reporting periods resulting from disposition of depreciable assets	0
7.	Amount Due Provider (Sum of lines 22 and 23 plus or minus lines 25 and 26 minus line 24)	6813534
8.	Sequestration Adjustment (See instructions)	0
9.	Amount due after sequestration (line 27 minus Line 28)	6813534
0.	Interim payments	5962924
1.	Balance Due Provider (Program) (Line 29 minus Line 30)	38610
2.	Protested amounts (nonallowable cost report items) in accordance with HCFA pub. 15-II, sec. 115.2	0
3.	Balance Due Provider / Program (Line 31 plus or minus Line 32)	38610

LeBonheur Children's Medical Center,
December 28, 1993.

Nursing Director, Emergency Department,
Helena Regional Medical Center,
Newman Drive, Helena, AR 72342.

Dear Colleague: We are writing to ask your help in solving a problem which threatens the future of Pediflite, the Pediatric Critical Care Transport Services offered as a joint venture of LeBonheur Children's Medical Center and Hospital Wing. For the past 12 years, Pediflite has provided optimal stabilization and transport of the sickest children in our region, providing a team of a Critical Care physician specialist and a Critical Care nurse and respiratory therapist. Unfortunately, because of diminishing reimbursement, LeBonheur Children's Medical Center is forced to require referring hospitals to pay for transport services. I have attached a copy of the letter to your administrator further explaining our position.

Two actions have thus been taken to try to guarantee survival of the service. We have expanded our ground transport capabilities and can now offer ground transportation to those hospitals within a 90-mile drive. This option, which costs 1/10 that of the helicopter, should be the transport mode of choice for children for whom the helicopter's speed is not essential. Many of the transports we currently conduct by air would fit into this category. Exceptions would include unconscious closed head injury patients, shock with inadequate vascular access, respiratory failure with unsuccessful attempts at intubation, possible epiglottitis, etc. Also, cities not within a 90-minute drive are not considered for ground transport.

The second action has been to require referring hospitals to be responsible for the cost of these transports. Your administration should have shared this information with your medical staff and the emergency department staff who will be asked to authorize the transport. The emergency department physicians will be asked to sign a form documenting the medical necessity for the transport. A signature by the emergency department physician acting as agent for the hospital or an employee of the hospital will also be required accepting financial responsibility for the transport.

It is our desire that the financial issues never be allowed to detract from the efficient medical care and the transport of the child. Therefore, it is all the more important that this matter be discussed openly with your hospital's administration as soon as possible. We would appreciate your sharing this information with the emergency department staff.

Our goal in these difficult times is the same as yours—to continue to provide the best possible care, including transport, for all critically ill and injured children. Please feel free to call us if you have any questions or other thoughts or suggestions. We welcome your input.

Sincerely,

Pat Peppler, RN, MSN,
Vice President, Nursing Services.

Enclosure

EMERGENCY ROOM STATISTICS PATIENTS TRANSPORTED

JANUARY–DECEMBER 1993

Hospital	Private car	Ambulance	Helicopter
Arkansas Children's Hospital	4	22	22
Baptist, Memphis	5	22	6
Baptist East, Memphis	2	13	0
Baptist, Little Rock	0	0	1
Baptish, unknown	0	4	2
Bridgeway	1 (WHPD car)		
Dr. Barr, Mississippi	0	1	0
William Bowld	0	1	0
Campbell's Clinic	5	7	0

EMERGENCY ROOM STATISTICS PATIENTS TRANSPORTED—Continued

JANUARY–DECEMBER 1993

Hospital	Private car	Ambulance	Helicopter
Doctors Hospital	5	10	1
LeBonheur	5	2	0
Little Rock, hospital unknown	5	2	0
The Med	2	16	10
Memphis, hospital unknown	1	2	0
Methodist, Memphis	0	8	1
Methodist, location unknown	0	1	0
NWMRMC	1	2	0
Pine Bluff, Jefferson	0	1	0
Pine Bluff	0	1	0
St. Francis	2	0	0
St. Vincent's	1	9	3
UAMS	1	18	3
VA, Little Rock	1	0	0
VA, Memphis	0	2	0
Wilson Clinic, Little Rock	1	0	0
Unknown	3	3	0
Total	45	147	49

Total—241

STATEMENT OF MIKE McBRIDE, ADMINISTRATOR, RANDOLPH COUNTY MEDICAL CENTER, POCAHONTAS, AR

Mr. McBRIDE. President Clinton, Mrs. Clinton, and Congress are to be commended for tackling the issue of health care reform. Health care reform is a topic of great controversy and emotion. Whatever is legislated will have far-reaching effects on the future of our country. Individual welfare and the health of our economy will be forever affected.

With that opening, I would like to take this opportunity to discuss several concerns and recommendations regarding the improvement of the health care system. I offer my comments as a taxpayer, a voter, a small businessman, and a provider of health care in rural Arkansas.

Everyone agrees that there should be universal, affordable coverage for medical catastrophe. The debate centers on how to reach this lofty goal. Managed competition, as outlined in the Managed Competition Act of 1993, is the best answer.

The Managed Competition Act is a market based approach to reform. It guarantees access to high quality, affordable health care for all Americans. It rejects government controls in favor of establishing ground rules for fair and effective competition among private health plans. It does not include global budgets or price controls, nor does it compel employers to pay the health plan premiums of their employees.

The Managed Competition Act motivates consumers to shop wisely for health plans by using strong tax incentives to encourage providers and insurance companies to form health partnerships, which will be publicly accountable for costs and quality. Regional purchasing cooperatives will give small businesses and individuals the benefits of greater buying power. Health plans would receive tax-favored status only if they offered a standard benefits package, complied with insurance reforms, and disclosed information on medical outcomes, cost effectiveness, and consumer satisfaction.

The President's plan has been called managed competition, but it appears long on managed and short on competition. His financing solution includes Medicare and Medicaid cuts, sin taxes, and slashing wasteful spending. These are not economically realistic, and are insufficient to achieve the goals of reform.

The most critical flaw in the President's plan is allowing Medicare and Medicaid to survive, and then proclaiming that reduced increases from these programs will fund reform of the system. Inadequate payments from Medicare and Medicaid and the related cost shifting are the reasons there is a health care crises today. Providers, especially those in the inner cities and rural areas that treat a disproportionate share of the elderly and poor, cannot survive deeper cuts in Medicare and Medicaid.

How does the Managed Competition Act address these flaws in the President's plan? Cost savings will be achieved through enhanced competition among health plans, malpractice reforms, electronic claims processing, and administrative simplification. Creation of a new bureaucracy is avoided, savings hundreds of millions of dollars. The overall cost of the plan is estimated to be $25 billion a year, compared with at least $70 billion a year in new Federal spending, and $70 billion a year in mandated new employer spending for the Clinton plan.

The reforms of the Managed Competition Act would be financed by capping employer deductibility of health benefits; reducing the increase in provider fees under Medicare slightly; phasing out the Medicare Part B premium subsidy for upper income beneficiaries; and pre-funding Federal retirees' health benefits.

The goals of health care reform are varied and far-reaching. Universal coverage; reducing the budget deficit; free choice of physicians; and unrationed access are a few of these goals. Again, a dose of reality is needed. A prioritization is necessary.

The American health care system is not completely broken. Replacement or a complete overhaul would be overkill. What is needed is an extensive tuneup, and this process has already begun. Physicians and hospitals are joining hands with insurers, businesses, and consumer groups. Greater prudency, efficiency, and competitiveness are quickly evolving. Brakes should not be applied to this process; a map and guide are what is needed.

The Managed Competition Act takes what is working, eliminates many of the problems, and is financially responsible. Clearly, the answer is not a massive new government program. The VA system is living proof of what a government dominated health care system might look like, a bureaucratic nightmare that has led to poor quality.

As a rural provider, I recognize the special role of rural health care, and the responsibility we have to our community. We are committed to improving the quality of care we provide, and doing so for the lowest possible cost. Health care reform is essential to accomplishing these goals. Our primary mission is to meet the needs of our local community, and we will work in support of the health care reform package that will not just promise, but that will deliver. Together, our challenge is to preserve the world's highest quality, most advanced health care, and to make the American people secure that they will always be insured.

The CHAIRMAN. Thank you very much, Mike.

Dr. Yates, how much money do you spend, if you know, on filling out insurance forms in your office?

Dr. YATES. I do not know exactly, but I know that when I entered practice I had one employee. I now have 10.

The CHAIRMAN. You now have 10?

Dr. YATES. Yes.

The CHAIRMAN. All doing what one used to do?

Dr. YATES. We have increased our doctors, so it is hard to say. We have two ladies right now who spend all day every day doing nothing but dealing with insurance companies, and we really need a third.

The CHAIRMAN. It really is not just filling out forms, you also have to call to get authority for certain procedures, do you not?

Dr. YATES. Well, let me give you an example of what happened to a patient this past week. A patient needed bladder repair. Some controversy, and you can read the literature about whether you remove her uterus, do a hysterectomy at the same time. We called the insurance company and we got prior approval for this, and they pre-certify the patient.

The patient comes to my office. Obviously, I believe in this procedure, and having read the literature and studied, and with my experience, I think this is the proper procedure. Her family doctor has referred her to me, and referred her to me because he felt that was the proper procedure, and trusted me to do it.

The day she comes to my office to go over last minute details, with surgery scheduled 2 days later, the insurance company calls and says, "We are not sure you can remove her uterus. Maybe you just need to repair her bladder."

So, as I am about to walk in the patient's room, what do I tell this patient? Fortunately, the insurance company relented and allowed me to perform what I felt was the proper procedure on this patient, and the patient has done well and is going home today. But this took an inordinate amount of my time and my secretary's time to deal with this, and really we ended up doing the same thing.

The CHAIRMAN. I take it this is the reason your fees have doubled and your income has stayed the same?

Dr. YATES. Yes, sir.

The CHAIRMAN. You are familiar with this so-called gatekeeper provision——

Dr. YATES. Yes, sir.

The CHAIRMAN. —in this bill, where you would have to get authority to go to some doctor? For example, if I did not want a

doctor in Jonesboro to do a heart bypass, I said, "I want Dr. Kooly in Houston to do it."

Dr. YATES. Yes.

The CHAIRMAN. Under this bill you could not do that, could you?

Dr. YATES. Correct.

The CHAIRMAN. Unless you got permission from a gatekeeper, and you convinced him that there was not anybody competent within the alliance—which we will say is Arkansas —to do that.

Dr. YATES. Right.

The CHAIRMAN. What is your feeling about that gatekeeper provision?

Dr. YATES. I think there are some advantages to that. Family doctors can provide a lot of care, and they can provide it cost effectively and cheaper than I can.

For example, I can do PAP smears, and I do, and a lot of ladies want to come to me to have their PAP smear done. But it is really not cost effective of the time I have spent in training, and specialty care training, to have me doing PAP smears. So, for them to go see their gatekeeper to get their PAP smear, I think is very cost effective, and I think that is a good part of the program.

The question is about good gatekeepers. It is sort of like everything else in life: If you do everything perfect, then any system will work. If we have good gatekeepers who refer the patient at just the appropriate time, then we are going to be fine.

Our concern is that under the current system you are encouraged to do procedures and to do things because you get paid for doing those things. Under the new system, you are going to be encouraged not to do things. And most people feel that with the system called capitation, which everybody thinks that this program will move to in 3 to 4 years, that at that point in time I am not going to be paid for not doing hysterectomies. That is fine if the lady does not need a hysterectomy.

But if she needs a hysterectomy and I tell her, "Just go home and bleed, it is not dropping your blood count," then she cannot go to work, then she cannot function. All people have, really, is our time, and we trade our time for money. If we cannot keep our employees working and healthy and on the job on the farm, and if those farms do not get tilled, and crops planted, then we do not make any crops.

So, I think that the gatekeeper system has some merit, but I think we need to be very careful to build in some kind of bypass system, so that the patient can, if they are unhappy with their gatekeeper, see another physician. Does that answer your question?

The CHAIRMAN. Yes. Dr. Yates, how many doctors are in this clinic you are in?

Dr. YATES. Six at this time.

The CHAIRMAN. Six?

Dr. YATES. Yes, sir.

The CHAIRMAN. Do you know, just offhand, how much unreimbursed care you provided last year in that clinic?

Dr. YATES. Fortunately, due to the Medicaid program in the State of Arkansas, we do not provide a lot of unreimbursed care, we provide a lot of low cost care. The Medicaid program, about 2 or

3 years ago in the State of Arkansas, pretty much covers most pregnancies.

Most of our work is pregnancy care and gynecologic surgery, so we provide 10, 20 percent, probably, unreimbursed care. Those are just people, for example, that do not bother to go get their Medicaid, and tell us they have got it, or it runs out, or something. Not being reimbursed is not our problem. Our problem is low reimbursement.

When I started practice I had approximately a 25 percent Medicaid practice. Our clinic has always taken Medicaid, because I feel very strongly about taking care of indigent patients. I probably would have been a Medicaid baby when I was born. My folks grew up poor in Heber Springs, and I have been educated by the State of Arkansas, so I feel very strongly about providing care for these people.

At the same time, what is being forced on us now is not right. I will have patients with insurance who come in, like a lady the other day, and I do not blame her. If I can get my car for free at one place, and I pay for it at another place, I am going to get it at the free lot. She came in, she had insurance, of which I would get paid the $1,600 as I mentioned.

Her husband decides he is going to switch jobs, so he switches jobs. He does not have coverage, he does not have anything. He does not say, "Well, since I am going to switch jobs, I guess I am going to owe you and the hospital the money." He says, "We will go get Medicaid." Now, she delivered her baby yesterday. Her Medicaid is not approved. Will we get paid? I do not know.

Our problem is working with the programs that are telling us what we can and cannot do, and they plop down a Medicaid card and do you dismiss this patient that you have followed for most of the pregnancy? No, we take care of them. So we are not really hurt by not——

The CHAIRMAN. Not being reimbursed?

Dr. YATES. Right.

The CHAIRMAN. Dr. McDaniel, would your answer to that be essentially the same?

Dr. MCDANIEL. No, sir. I deal with a different population.

As I pointed out, we are in a pretty rural area. We have a low income area. We have a high Medicaid census. The majority of my patients are Medicaid. As I pointed out, a lot of them are teenagers, unmarried.

The CHAIRMAN. What does Medicaid pay for delivering a baby? You said you delivered, what, 400 babies last year?

Dr. MCDANIEL. No, sir. Last year, I only delivered 250. We have got a new OB-GYN there.

The CHAIRMAN. What does Medicaid pay you as a fee for delivering a baby?

Dr. MCDANIEL. It is pretty close to $900 for package care. That is for the whole 9 months.

The CHAIRMAN. That is prenatal and delivery?

Dr. MCDANIEL. Prenatal and delivery. And I accept assignment.

The CHAIRMAN. Do you accept assignment, Dr. Yates?

Dr. YATES. Yes, sir.

Dr. McDANIEL. Now, one thing that has been unique in our area. Our private pay patients, which he gets a cross-section of all paying patients, our patients are being drafted from our community to the bigger cities under these network programs, managed care, HMOs. And it has gotten to where now primarily I just deal with Medicare on the OBs. And that sounds like a lot of money, but it is also a lot of nights and a lot of time.

The CHAIRMAN. Do you practice alone, Dr. McDaniel?

Dr. McDANIEL. I am a solo practice. I am a dinosaur.

The CHAIRMAN. I was the same kind of lawyer. Matter of fact, you are being addressed at this very moment by the whole South Franklin County Bar Association.

But let me ask you another question, and that relates to this disproportionate amount of money that you get from Medicare and Medicaid because a disproportionate part of your practice is Medicare and Medicaid. Do you also receive a fee for that, Dr. Yates?

Dr. YATES. Yes. About 60 percent of our OB right now is Medicaid. Fifty to 60 percent of all OB in the State of Arkansas is Medicaid. So if you are an OB doctor, you have a Medicaid practice.

The CHAIRMAN. Well, you also get a payment for Medicare services, too, do you not?

Dr. YATES. No.

The CHAIRMAN. You do, though, do you not?

Dr. McDANIEL. Yes, sir, but they do not have babies.

The CHAIRMAN. Well, I know they do not have babies, but do you not get a certain amount of money if you have a high percentage of Medicare?

Dr. McDANIEL. Yes, sir, I am a participator in the Medicare program, too, and they give 10 percent on that Part B program for being a rural doctor.

The CHAIRMAN. Now, you said in your testimony you are going to lose that, and that is going to really hurt under the present plan.

Dr. McDANIEL. No, sir, I am not personally going to lose it. I will not lose that part, as a practicing physician.

The CHAIRMAN. Well, you mentioned a $600,000 figure here.

Dr. McDANIEL. This was the disproportionate amount reimbursed by our hospital, not me as a physician.

The CHAIRMAN. Oh, by the hospital?

Dr. McDANIEL. Yes, sir.

The CHAIRMAN. Well, I was going to say, the University Med Center says this is critical to their survival.

Dr. McDANIEL. They have got to have it. And our hospital has to have it. There is no way to deliver all these babies without having a hospital.

The CHAIRMAN. Yes.

Dr. McDANIEL. With the way COBRA is structured now, it is almost impossible to transfer patients who are in labor anymore. Dr. Yates worked at the university, and he took care of a lot of these folks, and he gets worse situations than we get. We cannot take care of those without some means of transportation, and we have also got a place to deliver them.

We deliver between 500 and 600 babies in our community. If we had to send them to all these other hospitals——

And the reason I was pointing out our geographic location, it is about 110 miles to Little Rock, it is about 50 miles to Forrest City, it is about 60 to 65 miles to Memphis. Clarksdale is our closest hospital in, and they do take some of our Medicaid patients, but they are not primarily enjoying the practice of just doing Medicaid. I am sure if they had to take all 400 of them, they would probably say, "Wait a minute. You all keep them over there."

The CHAIRMAN. Dr. McDaniel, how many doctors are there in Phillips County?

Dr. MCDANIEL. There are 20 doctors who practice in Phillips County.

The CHAIRMAN. Are all of them on the staff of the hospital there?

Dr. MCDANIEL. Yes, sir. Not all are primary care physicians.

The CHAIRMAN. Sure.

Dr. MCDANIEL. We are fortunate. In the last 2 years we have been fortunate to recruit some new doctors to come to our area. Our older doctors were all retiring, and due to illness or even death, we lost quite a bit of our doctor population there for awhile. We were down to about 14. Recently we recruited an OB-GYN, an internist and a general surgeon, which really helped our situation out. And I feel like we give good care.

The CHAIRMAN. I did not know you had done that. That is very encouraging to hear.

Dr. MCDANIEL. Yes, sir.

The CHAIRMAN. Mike, I take it you favor Congressman Cooper's bill?

Mr. MCBRIDE. Yes, although I think the President's bill is manageable. Obviously it is going to be open to some amendments, and there are some flaws. One of the flaws I did not point out is—and I say this with all respect to the lawyers, but there has to be some sort of tort reform. I think the physicians would agree that if we are really going to reform the system and have some kind of cost effectiveness take hold, we have got to couple that with some tort reform to give these doctors a break, so they are not practicing the defensive medicine that they are forced into now.

The CHAIRMAN. How many beds are there in the Randolph County Medical Center?

Mr. MCBRIDE. We are licensed for 50 beds.

The CHAIRMAN. What is your average occupancy running now?

Mr. MCBRIDE. Average, we run 15 to 25 patients.

The CHAIRMAN. And you are making it on that?

Mr. MCBRIDE. We are scraping bottom. We were in a situation not unlike Helena, where we were way down on physicians. We have been successful in recruiting some new physicians, so we are——

The CHAIRMAN. How many doctors are on your staff?

Mr. MCBRIDE. Right now we have eight physicians.

The CHAIRMAN. Now, you are licensed for 50 beds?

Mr. MCBRIDE. Yes.

The CHAIRMAN. And your occupancy rate is running 15 to 20?

Mr. MCBRIDE. We have 10 beds that are dedicated to a geriatric/psychiatric unit, so——

The CHAIRMAN. Yes. That has been your salvation, has it not?

Mr. McBRIDE. That really has been helpful to us. So, out of those remaining 40 beds, we run about 15 patients, average.

The CHAIRMAN. I take it that your unreimbursed care is not a big problem for you, either, is that correct?

Mr. McBRIDE. It would be similar, I guess, to what Dr. Yates said. Unreimbursed care probably runs around 5 percent or so. Our bigger problem is the poor reimbursement from the Medicare program. Medicaid is pretty fair to us, but Medicare is——

The CHAIRMAN. How many RNs do you have in that hospital? On the hospital payroll.

Mr. McBRIDE. RNs? Approximately 20 to 25.

The CHAIRMAN. What is the average wage of an RN?

Mr. McBRIDE. Average wage, hourly rate without shift differentials and weekend differentials, in Randolph County, is about $12 per hour.

The CHAIRMAN. Twelve dollars an hour?

Mr. McBRIDE. So, $25,000 a year.

The CHAIRMAN. What is it in the private sector? How many RNs do you have in your office, Dr. Yates?

Dr. YATES. We had one RN for awhile. It is just not cost effective for us. We cannot use——

The CHAIRMAN. You really do not need an RN very much, do you?

Dr. YATES. We do not need an RN.

The CHAIRMAN. You know, Betty spends so much time with this, and she has been a great champion of nurses. And, I do not want to hurt your feelings. She says nurses do all the work and doctors get all the money. But, anyway, she is extremely sympathetic to the nurses, and they do work hard.

Dr. McDANIEL. They do work hard.

The CHAIRMAN. But there is a growing chasm between a new class of nurse, called nurse practitioner, and the medical profession. If you would like to see them sometime, I have some articles in this briefing book that points up the American Medical Association's concern.

As a product of a small town where the county health nurse came to our school and vaccinated everybody in the school—I happen to think that is an excellent idea. I think school based nurses, completely aside from the Dr. Elder's controversy about dispensing condoms and all that sort of thing, I think school based nurses are wonderful. I also think having a nurse practitioner in virtually every school in the country would be a very fine thing. We are not likely to ever reach that point.

But, the first order of learning in school is order. You first have to have order. Then you have to have healthy children who are not distracted by either lack of eyesight, or dyslexia, or a hundred other things. So I think nurse practitioners in school is a dynamite idea.

Nurse practitioners are not trying to supplant doctors, they are not trying to take over the primary health care delivery system of the country. I think they can do an awful lot of things that would maybe be less expensive if they did it than if a doctor had to do it. Would you comment on that, Dr. Yates. You do not have to agree with me, I just——

Dr. YATES. I agree 100 percent. A lot of other physicians do not, but I do. And that is the point I would like to make this morning.

For example, the health departments in all these communities around here provide a lot of prenatal care. The problem is that they provide prenatal care, and then there is no real bridge to get the patient in, except our personal relationships like we have developed with Wanda Hogue, where she knows she can rely on us to see her patients, and we deliver them.

There is not a system that provides continuity. If it was not for me and our group and some other things that we have been willing to do, then these bridges would not be there. And if somehow we can develop a system where—say in Helena they obtain more primary care doctors because they really need them. Like in Jonesboro we have some nurse practitioners, and possibly even nurse midwives that can do the routine, uncomplicated delivery.

For example, at the University of Tennessee, they get killed with deliveries down there by the indigent Memphis population. Seven thousand indigent deliveries. They just need somebody to come in and deliver those babies. The residents can hardly learn from just doing routine deliveries.

So I do think there is some mechanism for this, but I think where it is falling apart is like, when I was at the University of Tennessee we had midwives—well, they were not midwives, they were kooks. They wanted to do underwater births, and they wanted to do all this other stuff, and so all the physicians got turned off by it. So I think that is where a lot of the physician apprehension goes, is not the concept, but what has actually, in practicality, taken place, which is unsupervised practitioners or unsupervised midwives or people who are doing crazy things.

The midwife program in Mississippi County is one of the stellar examples in this country. Unfortunately, the lady that has made it work is retiring, and trying to find a replacement for this dedicated individual is just about impossible.

The CHAIRMAN. Ninety percent of the births are fairly normal, are they not?

Dr. YATES. Yes, sir.

The CHAIRMAN. Would occur with or without a physician in attendance?

Dr. YATES. Yes. I tell people I am like an insurance policy. My capability is to do an immediate Cesarean section and a few other things that I do. The rest of the time I provide comfort, and some pain relief, and just general reassurance. But I am like your insurance policy: You cannot wait until your house burns down to go get me. And that is the way prenatal care is.

The CHAIRMAN. Yes. Let me ask you and Dr. McDaniel this question. Just off the top of your head, in this basic package let us assume that the State of Arkansas is an alliance. And that is likely.

To tell you the truth, my job this next year is going to be tough. But once we pass this bill, in some form, and it has alliances in it, you know who has the tough job? The Arkansas legislature and the governor of Arkansas. Now, that is going to be a killer for them to work out all the kinks of how this alliance is going to work in our particular state.

But, as you know, every alliance will have a basic package of coverage. And, of course, insurance salesmen are genuinely and legitimately apprehensive, because there is not going to be any place for the ordinary guy who goes to the plant or to the individual to sell health insurance. He is going to be out of business.

Now, he can go around selling something in addition to the basic package, much as people have sold Medigap and all those things in addition to Medicare, that say, "You want the deluxe package? Here is one you can buy for $40 a month. Now, it will take care of your deductible and a few other things that would not otherwise be taken care of." But here—let me ask you: What should be included—and if you can think of a few things—what should be excluded from this package?

Now, we know that, as I said, breast implants, hair transplants, face lifts, liposuction, all those cosmetic things you can say, just off the top of your head, "Those ought not to be covered under this kind of coverage," and most of them are not covered under policies today. But what other kinds of things can you think of? Elective surgery?

Dr. YATES. Sort of depends on what you mean by elective.

The CHAIRMAN. Well, something you could do without, that is not critical to your life or to your well-being, somebody——

I am kind of like you, Doctor, I am not sure what I am talking about, either.

Dr. YATES. Well——

The CHAIRMAN. We talk about elective surgery as though it is something that you can do or not do. But if you happen to be that particular person, it is not so elective with them.

Dr. YATES. Well, for example, a tubal ligation is an elective surgery.

The CHAIRMAN. Yes.

Dr. YATES. But one of our problems right now, under the Medicaid program, if you are 20 and you have had 4 babies, you cannot get a tubal ligation. Because you cannot get a tubal and have Medicaid pay for it until you are 21.

Now, I can do a free tubal, of which I do many, but then the hospital does not get paid, and the anesthetist does not get paid.

The CHAIRMAN. Right.

Dr. YATES. So then we ask that lady to wait until she is 21. Well, maybe she has not been real good with birth control, so she has yet another baby.

Hysterectomy: Well, it is elective. She is not going to die. She just hurts all the time. She cannot work, she is in bed 5 days out of the month, you know; she is off work or she cannot take care of her family. Most people around here work.

The CHAIRMAN. What kind of a PAP smear do you normally get in order to recommend a hysterectomy? Two-plus?

Dr. YATES. By that class system, 3 to 4.

The CHAIRMAN. Do they still use that?

Dr. YATES. Yes. That has been replaced with the Bethesda system, which is a new classification, which has muddied the water even worse. That was a good system.

The CHAIRMAN. Yes.

Dr. YATES. So what is elective surgery? I think that is my problem. Obviously cosmetic surgery; but that bullet has been bit a long time ago, as somebody explained to me the other day. That is not covered by hardly anybody right now.

Fertility is a big question. A test tube baby costs you $6,000 for a 30 percent chance of having a baby. I personally think that probably is not going to be covered.

I belong to the American Fertility Society. That is a big problem for them. So I think basic care, a lot of preventive medicine: annual exams, mammograms, PAP smears. If we do all that, we will cut costs. I think those kind of things ought to be encouraged.

The CHAIRMAN. I agree. You see, those things are elective, but as I said, preventive health care is where you save money.

Dr. YATES. Prenatal care.

The CHAIRMAN. Right.

Dr. YATES. There have been a lot of studies that show if a factory will get prenatal care for its employees and allow them time off work, to not be on their feet, they will save money on their insurance because they will not pay for these bad babies. But I still cannot convince a factory to let their employee lay down for 15 minutes every shift.

The CHAIRMAN. Dr. McDaniel, do you have any thoughts on that? We are talking about the basic package.

Dr. MCDANIEL. Yes, sir. My thoughts were: First, you have to define what elective surgery is. And some of the things that Dr. Yates was talking about I do, myself. Tubal ligations, this looks like a necessity type thing to me, to cut down on costs. Because, like he says, while you are waiting for a young lady to be 21 years old, a lot of times she will have 2 or 3 babies.

I have had young ladies have 4 pregnancies, 4 C-sections, and because of her age the state law will not allow me to tie a young lady's——

The CHAIRMAN. All before she was 21?

Dr. MCDANIEL. Yes, sir.

Dr. YATES. All before she is 21.

Dr. MCDANIEL. And it is a shame. I do not even know if I could have done it with her consent, without any pay in a situation like that.

The CHAIRMAN. Well, that reminds me, when you get into this abortion thing, you are talking about rape and incest.

Dr. MCDANIEL. Yes, sir.

The CHAIRMAN. I went out to the med center one day. I hate to even say this. They have 13, 14 year old children there having babies by their fathers, by their brothers. And anybody that thinks that is not a problem is living in a dream world.

Dr. MCDANIEL. That is right.

The CHAIRMAN. It is so bizarre and so barbaric, it is really difficult to talk about, and yet it happens.

Do you resent this idea of a gatekeeper? Not just having a gatekeeper, but do you resent the idea of having to call somebody at an insurance company to see whether you can proceed with a particular procedure or not?

Dr. YATES. I resent the insurance company. Why? Because frequently the person you are talking to at an insurance company is

somebody that has not seen this patient, and does not know anything about the particulars, the social problems, medical problems, etcetera.

I have a different feeling about gatekeepers. We have worked with a gatekeeper around here for a long period of time. I have a lot of gatekeeper type arrangements that I already belong to through various companies. I have not found that to be a problem, because usually what happens is that it speeds up the process for me, because these primary care family doctors have seen the patient, they have done all the simple stuff, and the patient comes to me and says, "Well, I am bleeding all the time, and my doctor has already put me on antibiotics, and he has done a biopsy, and he has done a D&C, and he says I need a hysterectomy."

And I say, "Yes, ma'am, you do. I can do that next week." I see her one time, it is a short visit. I just confirm the findings of the family doctor, concur, get the lady scheduled, get her taken care of. I see her for one post-op visit, and she is back to this doctor who balances her hormones against her blood pressure medicines, against everything else, and I go down the road and take care of the next lady who needs my services, that the State of Arkansas has trained me to do.

The CHAIRMAN. Let me make a comment on something you said awhile ago, Dr. Yates, because I grew up poor, too. I am not very patient with my brother and sister, both of whom happen to be rich. I am still a Democrat.

This does not really have much to do with what we are here talking about. It is a political statement, I guess. But last summer, when we passed the so-called deficit reduction package, there are only two ways to reduce the deficit, and both of them are very unpopular. One is to raise taxes, and one is to cut spending. But you have very volatile groups on both sides resisting. So I voted for it. You know, if you had your way, you would not want to make all that many people upset with you.

So my brother—we are really very close, and we do not pull any punches with each other—and he called and he said, "All you damned Democrats think about is getting in my hip pocket."

And I said, "Well, now, smell you." We grew up better off than most, because we had a two-holer out back. Most people in town only had a one-holer. So, I went in the Marine Corp in World War II, and he went in the Army. We spent 3-plus years, came home, and a caring government had the GI bill waiting for us.

He goes to the University of Arkansas. He had finished his undergraduate work, because he was valedictorian of his class and got a scholarship, not because my father could afford it, though my father would have stolen to give us a good education.

He went on to the university and got his master's degree, and I went on and started into my sophomore year. I had gotten in one year before I went into the Marine Corp. When we got out, here was the GI bill waiting for us to go wherever we wanted to go, almost.

So he chooses Harvard Law School. He goes to Harvard Law School, the most expensive school in the country, and the taxpayers paid for every nickel of it. And I said, "You think about you squawking about how much tax you paid."

I would hate to tell you in public how much tax he pays. He makes a lot of money. And I said, "You know what you and Margaret and I did that a lot of people do not have a chance to do?"

And he said, "What?"

I said, "We chose our parents well." See, it will get you called a liberal sometimes for saying these things. But, I am a strong believer in welfare reform. I think that we have just talked around it and so on. We have got to do something about it. You cannot be politically correct anymore and deal with it. You just have to be pretty hard-nosed about it. You've got to start talking about Norplants and things like that.

But I told him, he really did not mean that. If you knew him, you would know he was boasting about how much tax he paid as much as he was complaining.

But I said, "You think about the chances you and I had. I believe in giving children a college education if they are willing to take it." I am willing to give people every chance in the world that never had a dog's chance. If they do not want to take it, then I do not owe them anything else, and the people of this country do not owe them anything else. But I know how fortunate I was to have had good parenting.

My sister used to go around saying, "Why can everybody not be rich and beautiful like me?" I used to tell her this same story, too. The truth of the matter is a lot of people do not have a chance. But I believe in giving them a chance. And if that makes you a liberal, so be it. Once you give them that chance, they do not take it, that is another matter entirely.

I want to thank all three of you for being here this morning. It has been very helpful.

Thank you very much.

Dr. McDANIEL. Thank you.

Dr. YATES. I appreciate it.

The CHAIRMAN. Our final panel is from the public health sector. Ramona Taylor, administrator, Crittenden County Health Unit, West Memphis; John Eason, director, Lee County Cooperative Clinic in Marianna; and Wanda Hogue, who has already been prominently mentioned. Wanda is Area XI manager, Area XI Health Office in Walnut Ridge. Made it in the big time despite her husband.

Ramona, your name is first on my list, so please proceed.

STATEMENT OF RAMONA TAYLOR, ADMINISTRATOR, CRITTENDEN COUNTY HEALTH UNIT, WEST MEMPHIS, AR

Ms. TAYLOR. Thank you, Senator. It has been my privilege to serve the citizens of Crittenden County in my role as a public health administrator. I take great pride in that. We operate two full-time public health units in Crittenden County; we have a school based satellite in Turrell, where we also serve the public in addition to the school. We offer 19 programs or services in Crittenden County; we offer extended hours daily in West Memphis; and we have 55 employees.

This past year we provided prenatal services to 534 women and teens and these patients are followed by nurse practitioners

throughout their pregnancy. They deliver at the regional medical center in Memphis. Act 490 and/or Arkansas Medicaid pays for these deliveries.

There is one practicing obstetrician in our county, so we do the majority of the obstetrical prenatal care. Recruitment efforts to entice other obstetricians have been unsuccessful. We have also found Tennessee obstetricians unwilling to accept our Arkansas Medicaid patients, so we are the only choice for their prenatal care.

We use a team approach in providing prenatal care. We use the registered nurse practitioners, registered nurses, LPNs, public health technicians, social workers, and a nutritionist to provide direct care, case management, and home visits. We start discussing family planning options during their prenatal care. We offer Norplant, Depo-Provera, IUDs, and oral contraceptives. Last year there were 3,802 visits to our family planning clinic, and we are a major provider of family planning services.

Due to the large number of teens that we see coming through our clinic—and I can relate to the comments of Dr. Yates and Dr. McDaniel—we also see teens having their second babies. We started a mentoring program under the supervision of one of our RNs. We recruited some community volunteers, and currently we have nine teens in a mentoring program, to help them postpone a further pregnancy.

Child health services are also a major component of our work, as you certainly well know. EPSDT, immunizations, and WIC certification are provided daily. Our county WIC caseload is 3,200 children and pregnant women.

In 1987, the Turrell School District was financially unable to hire a school nurse, and we had no place to provide services for WIC and immunizations for the citizens of Turrell. So it was with suggestions from the county judge, we became the school nurse for Turrell, and they provide us space to provide services to the community. Family planning services are available to anyone in the community after school hours.

Four years ago we again received a call for help. The local medical community was unable to provide primary care for Medicaid and uninsured children, and requested our assistance. At that time, we opened a pediatric primary care clinic at the West Memphis unit. A pediatrician and two pediatric nurse practitioners provide comprehensive care, including hospitalization and 24-hour call care. We are providing, very definitely, primary care in that unit.

The clinic works closely with the private pediatric practice that includes sharing calls and hospital rounds with them. The start-up funds for the clinic were provided by the Arkansas Department of Health, a private pediatrician, the Crittenden County Medical Society, and the Good Neighbor Center. Recently the clinic began seeing sick children two afternoons a week at the Turrell School Clinic to address the problem of transportation.

The health department also takes a very strong role in looking at community health planning. We are a part of a multi-disciplinary community team to review all child sexual abuse cases. We make recommendations to the court, and we ensure that the child re-

ceives the medical and mental health services needed; 120 cases were presented in 1993.

And I associate with your comments earlier about what you saw at the medical center. It is devastating what children have to undergo at the hands of adults. Parent skills training has begun to help parents develop a more positive relationship with their children, so that we can reduce some of these numbers.

From the last 2 years, through a collaborative grant effort with the city of West Memphis and the West Memphis Housing Authority, we received funding for a health educator through a youth sports grant from HUD. The health educator has a full-time office in the West Memphis Housing Authority. There he serves as a role model, holds individual and group health promotion strategies on the housing authority grounds, and also at a nearby elementary and junior high school.

He spends his time encouraging youth to participate in Boys and Girls Clubs activities, baseball, basketball, volleyball, and 4–H, where he serves as a co-leader. Last summer he offered a series of violence reduction classes for the housing authority children, and will offer this series in the elementary school this winter.

We have a long history of providing home health services. Although we provide services to all ages, we specialize in babies. The public health nurse is often the only source of home services for indigent patients and those living in areas that are perceived to be undesirable. Those nurses are excellent in providing support for young mothers unsure of how to provide care, or even why this care is necessary.

Crittenden County is noted for its high incidence of communicable disease. From 1989 until 1991 we were first in the number of syphilis cases in the state. Our local response was to provide more sexually transmitted disease information through our maternity, family planning, WIC, and TB patients. This has resulted in a modest decrease from 163 cases in 1990, to 147 cases in 1992.

It is still a serious problem for us. The public health investigator has noted a decrease in syphilis cases in the West Memphis Housing Authority during the year the health educator has been there. So we feel that his working with the young men has been helpful. We also have a significant TB caseload of 24.

The nursing staff this past year has worked with local day care providers in controlling salmonella outbreaks, and an incidence of Hepatitis A. And I feel strongly that communicable disease is an area which should be expanded for public health and health care reform, so that we can do more intensive investigation, monitoring, and education.

Environmental services provide traditional services such as food service monitoring, septic tank permitting, and also works to promote recycling. As Crittenden County has two sites under EPA investigation, an expanded role in the environmental field is important in helping the local community, as well as the state, develop and implement community health planning.

My feeling very strongly, that unless public health retains an important role in health care reform, who will do these things that we have done? If we are allowed to expand, there will be a need for training monies for mid-level practitioners. We currently have

three registered nurse practitioners working at my site. We will need expanded funding for environmental services and statistical gathering and analysis.

Public health needs an adequate mechanism for providing for new or renovated facilities and sophisticated equipment, particularly at the local level. I feel that each public health department should be very visible in the community in regard to its location, and also its role in community planning. Public health, in the local level, has a good sense of needs in the "at risk" community, as well as expertise in implementing change to address the issues of inadequate housing, violence, and drugs.

Flexibility in the health care plan is extremely important to Crittenden County. A major regional medical center, The Med, is located within 10 minutes of us, but it is necessary to cross state lines. So if we consider the state line as our alliance, it would be a very serious issue for us, particularly in Crittenden County.

Both traditionally and logistically, Crittenden County is oriented to Memphis health care if services are unavailable to be provided locally. If services are removed from the health department sector, then it is important to allow time for a smooth transition so that the public will not suffer. Thank you.

The CHAIRMAN. Ramona, you have got a plateful, have you not?

Ms. TAYLOR. Yes, sir, I do.

The CHAIRMAN. John?

STATEMENT OF JOHN EASON, DIRECTOR, LEE CO-OP CLINIC, MARIANNA, AR

Mr. EASON. Thank you, Senator.

The people of Lee, Phillips, and St. Francis County are greatly indebted to Senator Bumpers, because Senator Bumpers——

The CHAIRMAN. You are starting off right, John.

Mr. EASON. —put his political career on the line in 1972, when he released $1 million to build the facility which we are in now, and which is serving three counties now. Also, we have some patients that come from St. Francis County, Senator Bumpers.

The CHAIRMAN. John, do you know most people in this audience do not remember that. You and I sure remember it, do we not? We had to send the state police down there.

Mr. EASON. Yes, sir.

The CHAIRMAN. For a week, to keep order.

Mr. EASON. You had two groups, one meeting in the morning, one meeting in the afternoon.

The CHAIRMAN. I'll never forget it. That was the toughest decision I made when I was governor. It really was not a tough decision to make, it was just a tough one to implement.

Mr. EASON. That is true, because you put your political career on the line when that was done. We appreciate that.

We have people now, as I say, coming from as far away as Cross County. We also need a new building now. We are not going to beg you about that; we are trying to get that by other means.

We applaud President Clinton for making health care reform one of his top priorities, and for presenting a plan that extends guaran-

teed coverage for comprehensive benefits to millions of people who are currently uninsured or inadequately insured.

At the same time, however, several elements found in President Clinton's draft health reform plan raise serious concerns about how well or poorly the reform health system will serve the unique needs of American underserved. And we work with the American underserved.

I know you heard Dr. McDaniel talking about how poor Phillips County is. We are poorer than they are; we are the eighth poorest county in the Nation. We are probably worse off now than that, because Tunica, MS has all these gambling facilities, and they have more money than we do, so I think we have probably slipped another notch.

In particular, his plan relies heavily on a system of managed competition under which several managed care type health plans compete to enroll and serve covered individuals. But managed care entities and HMOs have historically avoided the underserved because of their unique needs and inherently high cost for a vulnerable population.

Managed competition may not improve access to care, and could even prove detrimental. Even under the best of circumstances, it is often difficult to preclude discrimination against minorities, vulnerable populations, the poor, and others who do not fit the norm. I have a chart here with me.

You know, in the United States we have 248,709,873 people. People who are at risk numbers 50,983,816. Now, nationally that is 22.5 percent. But in Arkansas we have 2,350,725 people. We have 35.2 percent. We are number one in the population at risk. West Virginia is number two; Mississippi is number three.

Now, Senator Bumpers has been talking about his personal endeavors this morning. I am living on the same farm, Senator, that I was reared on. My mother told my father, she said, "Jerdan," his name was Jordan. She said, "Jerdan, I am not going to move onto another plantation."

So in 1943, I was 8 years old, we moved to where we are now. We bought a 40 acre farm, and I was reared there. I was telling the young people this morning, before the others got here, that I have had the same mailing address for 50 years, but 911 changed that, so I have a big number now, 333 Lee 236. You have to change with the times.

I am talking about a person who has experienced poverty in the delta—I was 15 years old, Senator, before I saw a physician. The reason why I saw a physician, I had a sister who was living in New Mexico. She had married a schoolteacher, and he thought he was pretty smart.

So they came home, and I was 6'1", 15 years old. I weighed 95 pounds. They said, "Boy, something is wrong with you." They said, "We are going to have to take you to the doctor." So they took me to a doctor up about 30 miles from Marianna, and they thought I had what they then called tuberculosis consumption. I have not grown but three-fourths of an inch since I was 15 years old, so I am 6'1¾". But due to old age, I am probably not 6'1¾" anymore, because when osteoporosis sets in, you get shorter.

But they took me and they started me on raw eggs and sweet milk. And when I started to high school in August, I finally got up to 125 pounds.

One reason why I did not weigh too much more, because my mother was a person like this: if she cooked it, you did not eat it, that was your problem. Now, parents will take their children and pet them, cook what they want, and all this. But I grew up in a situation where we just did not have. I went to high school on 50 cents per week, but it taught me how to manage my money.

One thing about the President's health care plan I have a few problems with, Senator, is financing.

If you noticed in Dr. McDaniel's testimony, he stated that some money is going to be taken from Medicaid and Medicare in order to take care of the program. But, now, you know we had a catastrophe in California, $30 billion. That money has to come out of the till.

But I think we are going to have to cut costs and also raise taxes. But, now, if you say "raise taxes," Senator, you are going to lose. But, now, we have to get into our people's mind that this country was founded on the principle of taxation with representation. Now we have representation, but we do not want to pay taxation.

To me, we are supposed to be very, very intelligent people. But I was telling a young man this morning, if my father had lived he would have been 104 years old. And he once told me, "Son, if you do not put money in the bank, you cannot go down there and get any money." So if we do not pay money to the government, we cannot get subsidies and we cannot get welfare.

Now, what is the difference between subsidies and welfare? Okay, this is the difference: Welfare is zero to four numbers. All right, subsidies go from one to six digits. That is the only difference. But they use different terms. When it is poor folks, it is welfare; but when it is rich folk, it is subsidized. But the only difference is subsidies are larger than welfare payments.

The CHAIRMAN. That did not cost anything extra, did it, John, all that?

Mr. EASON. No, sir. But I get on my soap box, Senator because we are supposed to be intelligent individuals. But we get what we pay for.

We want good police protection, we want good firemen's protection, we have to pay for those, sir. It is not going to be given to us. We have to have good schools. That is the reason why our schools are as bad off as they are, because we do not have finances. We do not want to pay local taxes, we do not want to pay Federal taxes. That cost 50 cents.

We think about access. Now, I am representing community health centers. In Arkansas, we have 34 access points for community health centers, Senator. When you were governor of the state, I think we had about seven or eight. We have seven cooperations, but we have satellites and what have you. We are getting new satellites. We have a new facility up at Marshall and we are getting them in other parts of the State.

You think about access. President Clinton's proposal to expand services in underserved areas contains no assured funding, and principally involves taking resources away from successful model

programs, like health centers, and giving them to totally new programs, which would target its resources to a wide variety of organizations, including private health plans with little or no community involvement. And when you are dealing with the poor folk, it is a little bit different because, as you have stated this morning, we always think about prevention.

When you are poor, you do not think about prevention. The only time you go to a physician is when you have to go. Because you just do not have the money to go. But by having community health centers in the regions, where people are familiar with the doctors and what have you, they do not mind coming and getting preventive care.

The President's plan recognizes health centers and others who currently care for the underserved as essential community providers, ECPs, and extend certain rights and protection, such as contracting and minimum payment requirements. But these protections will not fully safeguard ECPs, because we may get the sickest of people, the people who are at greatest risk.

And they may get us on productivity. As Dr. Yates and others know, for people who have not been in to get prenatal care, it takes more time to deal with them than it does the people who come in frequently. It is just like keeping your car maintained, or keeping your washing machines maintained, it does not take as much time.

Dr. McDaniel was talking about how they recruited new physicians into the Helena area. Well, you take in Lee County, Senator, we only have about 5.5 physicians, and 3.5 of those are at the community health center, which is Lee County Cooperative Clinic.

We would like to have legislation that would amend the Health Security Act in three specific ways: No. 1, access. It would call for a significant expansion of the community health center program, including flexible authority to make grants to other kind of providers, and to establish networks of essential community providers.

This differs from the HSA approach, Title III Service Expansion, in two ways. One, it would give preference to community-directed organizations that have insufficient capital to effectively participate in all health plans, as opposed to the HSA which prioritizes private providers, including "for profit" practices, and institutions that either always have or can easily access private capital funds. We are having that problem now. If the government does not finance the remodeling of the clinic, it is very, very difficult to get it financed.

It would assure funding for these new activities "equal to" the proposed HSA levels. Note, it would also move currently discretionary health center fundings into this guaranteed funding authority.

Now, as I understand it, Ms. Chaffey, during the first 3 years we would get an additional $300 million, but it will be taken back later, and we will have to compete for already scarce funds that are available. The competition that we have now is very, very great. We are not getting very much more money than we did when I first started there in 1977. It has not kept up with inflation. That is the reason why we try to run a tight ship.

A lot of times when you have government programs, people have a tendency to think, "This is not mine," and their money is wasted. But we do not waste money at the Lee County Cooperative Clinic.

Today we may have lights on in the waiting room. But on days we have sunshine, we even took the drapes down. It is not anything beautiful, Senator. We took the drapes down so we do not have to burn the lights. If we do not burn the lights, you save a few dollars. When you save a few dollars, you can buy more pills for the people you are serving.

Another typical example where we save money. When we go to various workshops, we do not stay in the most expensive hotels. If you are representing the poor, you cannot act like the Rockefellers. You have to act your part.

I am reminded about the joke where a child was going out and his mother said, "Now, son, if you keep your mouth closed, folk will not find you out." So he went off. And when people would speak to him, he would not say anything. And he stayed around there, and somebody said, "You know, this fellow will not speak. He must be a fool."

And the boy went back home and he said, "Mama, I did not say anything, but they found me out anyway." So people will find you out.

Policymakers, Senator Bumpers, should look hard at what has and what has not worked for the underserved people. Health care reform should build on what has worked: the community, migrant, and homeless health center programs.

Nothing else has our uniquely successful 30-year track record of controlling costs, providing access to quality care, retaining health professionals where they are most needed, or empowering the community to develop long-range solutions to their own health needs. Health reform should invest in such successes.

We want to work with you and the President, and we know that you will be at the hog trough for us, so that we will not be the runts.

Some of you may not know what I am talking about. Those of you who have lived on a farm, you have a trough where you feed your pigs. And when you put the food in there, the hog that is there gets the most of it. The one that is late usually becomes what we call the runt; he is the smallest one because he does not get as much nutrition as the rest.

So, Senator, we are at the trough. We do not want to be the runt. Thank you, sir.

The CHAIRMAN. Thank you, John. Wanda?

[The prepared statement of Mr. Eason follows:]

PREPARED STATEMENT OF JOHN EASON, DIRECTOR, LEE CO-OP CLINIC, MARIANNA, AR

We applaud President Clinton for making health care reform one of his top priorities, and for presenting a plan that extends guaranteed coverage for comprehensive benefits to million of people who are currently uninsured or inadequately insured. At the same time, however, several elements found in President Clinton's draft health reform plan raise serious concerns about how well or poorly the reformed health system will serve the unique needs of America's underserved.

In particular, his plan relies heavily on a system of managed competition, under which several managed care-type health plans compete to enroll and serve covered individuals. But managed care entities and HMOs have historically avoided the underserved because of their unique needs and inherently higher costs; for vulnerable populations, managed competition may not improve access to care, and could even prove detrimental. Even under the best of circumstances, it is often difficult to pre-

clude discrimination against minorities, vulnerable populations, the poor and others who don't fit the "norm".

Several efforts will be required to ensure that managed competition does not place underserved people and communities at the risk of being red-lined, short-changed and, in the end, getting far less than they need or deserve. Here, however, the President's plan falls critically short on several counts:

1. ACCESS: His proposal to expand services in underserved areas contains no assured funding, and principally involves taking resources away from successful model programs like health centers and giving them to a totally new program, which would target its resources to a wide variety of organizations, including private health plans, with little or no community involvement; resources are not targeted to underserved communities directly. This raises the distinct possibility that existing programs, such as the health centers, Family Planning, MCH, and Ryan White, will be pitted against the new program for scarce Federal resources, in which case all efforts will be hurt, and the vital objectives of health reform may not be achieved.

2. ESSENTIAL PROVIDERS: While his plan recognizes health centers and others who currently care for the underserved as "essential community providers" (ECPs), and extends certain rights and protections (such as contracting and minimum payment requirements), these protections will not fully safe-guard the ECPs against excessive financial risk and other forms of discrimination, such as assignment of the sickest patients, delays or denials of specialty referral requests, or attempts to disqualify ECPs for reasons such as low productivity, even though ECP patients may require substantially more time and hands-on care.

3. HEALTH PROFESSIONS TRAINING: His reform of health professions training leaves the medical schools and teaching hospitals—which are responsible for the current acute shortage of primary care providers—effectively in charge, and assures the payment to health centers and other ECPs only for direct training costs (but not for indirect costs), and then only if they operate such a program (but not if they participate in one).

We would like to have legislation that would amend the Health Security Act in three specific ways that follow:

1. ACCESS: It would call for a significant expansion of the Community Health Center Program including flexible authority to make grants to other kinds of providers and to establish networks of essential community providers. This differs from the risk approach (Title III Service Expansion) in two ways:

a. It would give preference to community-directed organizations that have insufficient capital to effectively participate in all health plans; as opposed to the HSA which prioritizes private providers (including for-profit practices and institutions that either always have or can easily access private capital funds).

b. It would assure funding for these new activities at equal to the proposed HSA levels. (Note, it also moves current discretionary health center funding into this guaranteed funding authority).

c. It should be noted that the Health Care Delivery System in Arkansas will exhibit a greater sensitivity to any Health Care Reform actions because of the rural nature of our State, the economic, social and environmental problems as exists in the Delta and the fragile nature of our rural health care infrastructure. The Community Health Centers of Arkansas are a major part of the rural health infrastructure.

2. ESSENTIAL PROVIDERS: It would call for strengthening the current ECP safe-guards by ensuring a reasonable payment rate through a cap coverage mechanism, already used by several states (Wisconsin and Minnesota) to make sure these providers are not put at undue risk. While the HSA does include key provisions recognizing and safeguarding the role of ECPs, it does not offer them adequate protection against excessive financial risk.

3. HEALTH PROFESSIONS TRAINING: It would encourage the inclusion of ECPs in health professions education and training by providing direct payment to cover the cost of their training efforts. The HSA only provides funds to those entities that operate accredited training programs—in effect, locking in the available funding to existing medical schools and teaching hospitals only.

Policymakers, as you Senator Bumpers, should look hard at what has and what has not worked for the underserved. Health care reform should build on what has worked: the community, migrant and homeless health center programs. Nothing else has our uniquely successful, 30-year track record of controlling costs, providing access to quality care, retaining health professionals where they're most needed, or

empowering communities to develop long-range solutions to their health needs. Health reform should invest in such successes.

We want to work with the President and the Congress to make health reform work for all Americans, and to support its prompt enactment. At the same time, we believe that, if health reform is to work for underserved communities, it must empower medically underserved communities to develop workable, permanent, responsive community health care systems. For this reason, our legislative proposal will be in the form of "perfecting" amendments to the President's plan.

We need your help in making sure that reform stays on track and works for our families and communities. You can do so by supporting and co-sponsoring our proposed legislative amendments.

STATEMENT OF WANDA R. HOGUE, AREA XI AREA MANAGER, AREA XI HEALTH OFFICE, WALNUT RIDGE, AR

Ms. HOGUE. Senator Bumpers, I am pleased to have the opportunity to testify about the implications of health care reform on public health. I speak from the perspective of a public health manager who oversees the operations of 12 local health departments in 9 counties in northeast Arkansas.

This 9 county area has a population of approximately 221,000, which has remained relatively constant since 1980. Over 69 percent of this population have incomes below 200 percent of poverty; 19 percent of the population is uninsured; 70 percent of the population lives in an area designated as medically underserved. In addition to the public health and private practitioners, we have one community health center, and one area health education center.

I have several comments which I believe are very important in regard to health care reform. I am very concerned about clients not having a choice of providers for a different reason than most people may raise. Our patients may change physicians because of how they are treated, or their perception thereof. Unfortunately, poor patients are not always welcome or treated with dignity.

In fact, these patients, for a variety of reasons, may need more intensive counseling and follow-up than the general population. Many times they are afraid to ask questions, or afraid to insist on an appointment, even when they are certain they need one. I believe many practitioners may need training on dealing effectively with vulnerable population groups.

Many of the clients in this "at risk" population were not raised to understand how their health—overall health will impact on their successes or failures in life. This is something which should be considered in any health care reform effort.

Another major issue for this area will be transportation. We have very little public transportation. We currently have patients who must drive 40 and 50 miles to reach a hospital to deliver their babies.

If I had been pregnant and went into labor in Pocahontas this weekend, with the snow and ice, I would have been panic struck, and might have died on the way over here, the roads were horrendous. This does not happen that often, but to one woman and one baby, that is a problem. Health care reform needs to address support for transportation systems development, even though this may not seem directly related to health care.

It goes without saying since 70 percent of our population lives in a medically underserved area, that we need incentives to entice physicians to practice in rural areas.

In particular, these practitioners must include obstetrics in their practice. In the past few years we have seen a dramatic decline in physicians who are willing to include obstetrics in their private practice due to the economics and cutbacks in Medicaid and health insurance, and also the dramatic increases in malpractice insurance.

In addition to recruiting and training primary care physicians, we need to expand the use of nurse practitioners and nurse midwives. In the health department we have been successful in sending public health nurses, who are local residents, to be trained as nurse practitioners. These nurses, who have ties to the community, are more likely to continue working there in the years to come.

We currently have our first nurse in nurse midwifery training. And I might say that Dr. Yates and his group is working with that nurse right now, and participating in her training.

Communities need flexibility to do what works best for them. We understand that in the Clinton plan much of the funding for public health initiatives continues to be in the form of categorical grants. This approach usually leaves little flexibility for community planning and local priorities, and increases the administrative burden.

One example of a local cooperative agreement that we are able to do as a result of the MCH block grant funding is to place a public health nurse in a private obstetrical clinic. The OB services are provided by the clinic staff; the public health nurse provides case management, prenatal education classes, and home visits. This arrangement enables the high risk or vulnerable patients mentioned earlier to get the services—the more comprehensive services that they need.

The CHAIRMAN. Wanda, let me interrupt——

Do you know of anyplace else in Arkansas where there is such an arrangement as that? That is unique. I have never heard of that before.

Ms. HOGUE. I do not know——

The CHAIRMAN. Between a public health nurse and a private obstetrical clinic?

Ms. HOGUE. I do not know of another place.

The CHAIRMAN. How long have you had that?

Ms. HOGUE. About a year.

The CHAIRMAN. Is it working well?

Ms. HOGUE. Yes, very well. I think Dr. Yates would tell you that, too.

The CHAIRMAN. Go ahead.

Ms. HOGUE. The services that this nurse provides are services that the physicians and their staff are not able to do, based on the large number of patients that they have to see in that practice.

Public health should be a major player in any reform system. Although our role will change, we think local health units will remain critical to the state because of the need for our environmental health services, communicable disease control activities, health education, and participation in local planning and networks.

In addition, public health has experience in dealing with hard to reach and vulnerable populations.

Outreach, tracking, transportation, case management, home visiting are examples of supplementary services these populations will continue to require for the reform system to be effective. All of these services will require adequate funding as part of the health care reform.

Our greatest fear is that it will be assumed that because we have universal health coverage, that public health is no longer needed. We know, and we know that you know, that is not true. Prevention and early intervention are the most cost effective and important cornerstones of any health care system we can develop. We also know that currently most physicians' offices are very busy, and sometimes it may take a couple of days to get an appointment, even when you need one really bad. This is in a world where we have Medicaid, and we still have a lot of people who are uninsured. If everyone has a health insurance card, then the doctors' offices are going to be only fuller of people who are sicker. And, so, we are really concerned about those patients being able to get appointments, and health departments can fill in those gaps.

Senator Bumpers, I would be remiss if I did not take this opportunity to thank you for all the support you have given to the health department and to public health in the past. In particular, your efforts in maternal and child health, and immunizations, and WIC have made a significant difference in the health of mothers and children in Arkansas. And I would like to thank you for allowing me to give you some of my views today.

The CHAIRMAN. Wanda, thank you very much.

The CHAIRMAN. You are kind, and I appreciate the compliment, as does Betty, because I know you really speak as much for Betty as you do for me.

You mentioned something at the conclusion of your testimony that is interesting, and you were not just sticking totally to the Clinton health care proposal. But what is the average wait from the time somebody walks into one of the clinics that you have jurisdiction over, until they see somebody? Either a nurse, doctor, or somebody that can help them?

Ms. HOGUE. It sort of depends on what service they are there for. If they come in for immunizations, we do immunizations 5 days a week, all day long. If they need a WIC appointment and they come in, most of the time we are able to see them that day, while they are there.

If it is a maternity patient, then we have to schedule her back in on the day that the nurse practitioner is there, but generally she will be seen in 5 to 7 days. Family planning we do at least 1 or 2 days every week, so it depends on what they are there for.

But we do not have long appointment schedules. With WIC sometimes it will take 2 weeks to get in if they call for an appointment and we give them one over the phone. But if they walk in, we try to take care of them when they are there. However, if they receive a nursing service, they will get in within 30 minutes of their arrival time.

And I might say that in the Craighead County Health Department here in Jonesboro, we have a caseload of about 2,800 on WIC,

and we do WIC 5 days a week in that clinic, so they are in the clinic all the time.

The CHAIRMAN. If you walk in and you say, "I feel wretched. I feel like I have got the flu. I have 102 degrees of fever," what do you do with somebody like that?

Ms. HOGUE. There really is not anything that we can do for that patient, other than refer them to the doctor. We do not do much episodic care at all, unless we have——

The CHAIRMAN. You just refer them to a doctor?

Ms. HOGUE. Yes.

The CHAIRMAN. John, how is your financial situation down there?

Mr. EASON. We are doing nicely, sir.

The CHAIRMAN. Are you doing OK?

Mr. EASON. Yes, sir, we are.

The CHAIRMAN. How many doctors do you have in the clinic now?

Mr. EASON. 3.5, sir.

The CHAIRMAN. Who is the "point five"?

Mr. EASON. Well, see, what happens, you——

The CHAIRMAN. You are talking about on an average yearly basis?

Mr. EASON. Yes, sir. You have one coming in so many hours a day and the other thing. You have to convert that to FTE, full time equivalent, sir.

The CHAIRMAN. Wanda, are you familiar with the nurse practitioner program?

Ms. HOGUE. Yes.

The CHAIRMAN. Do you think that people like that—for example, in the illustration I gave a moment ago, if you have a clinic in Pocahontas, let us say you have a public health clinic and you have 2 nurse practitioners in there, and somebody walks in and said, "I have a fever." Do you think a nurse practitioner should be able to examine them for anything that might be immediately apparent as a cause of that, or do you think they just ought to peremptorily, without exception, be referred to a physician?

Ms. HOGUE. I believe that there are a large variety of services the nurse practitioner, under a physician's guidance—and I think the critical thing, is that she has a backup physician that will give her standing protocols for certain treatments—can provide a very valuable role in that area. I think we are beginning to see some of that as we are seeing clinics started around this area, where there would be a nurse practitioner on site 5 days a week, maybe a physician come in 1 day a week, and she would be functioning under his protocols.

There would be a lot of patients that come through that she can treat and take care of; there would be others that would have to come back in and see the doctor. That is happening; hospitals and some private doctors' offices are setting those up already.

The CHAIRMAN. Ramona, do you want to comment on that? Do you believe strongly in nurse practitioners?

Ms. TAYLOR. Oh, yes, sir.

The CHAIRMAN. How many do you all have?

Ms. TAYLOR. I have 4 nurse practitioners most days. I have 2 doing primary care under the supervision of a pediatrician. You just helped me resolve my pediatrician problem last week, so I will have a full-time pediatrician starting on the 31st. This last 6 months I have been operating with a half-time pediatrician.

At any given time I might not have a pediatrician on hand, but have a sick child that the nurse practitioner feels is beyond her scope. We have an alliance with the local pediatric office, where there are 2 pediatricians, and they serve as our backup.

I think, as Wanda says, you have got to have that physician connection. I think that is important for the security of the nurse practitioner, so she is comfortable, and for the safety of the patient, too, to provide quality care.

The 2 practitioners I have doing women's health, they use physicians in Little Rock as their backup. They operate under their protocol, and they are available to them by telephone, and they are on site occasionally.

But I think our most unique arrangement is the arrangement we have with the local pediatricians, and then the fact that we have been able to hire a full-time pediatrician on site. And I think they are crucial in the delta.

West Memphis has tried for several years, and has spent lots of money trying to recruit primary care physicians, particularly family practice and obstetrics. In West Memphis family practice physicians do not deliver. We follow the Memphis rule, and they do not allow family practice doctors to deliver. Recruitment efforts have not been successful. And the hospital has put lots of money into this. But we——

The CHAIRMAN. Do you agree with that, not allowing family practitioners to deliver babies?

Ms. TAYLOR. I do not really feel like I am qualified to answer that. That is the way we have operated in Crittenden County. That is the way we have operated all my life.

The CHAIRMAN. It has been that way for a long time, has it not?

Ms. TAYLOR. Yes, sir. I know nationally there is a trend away from that, and I am sure they are looking at that.

The CHAIRMAN. It is confusing, is it not, that we have a midwife program——

Ms. TAYLOR. Yes, sir.

The CHAIRMAN. —and then say to them, "Yes, you can deliver all these babies of poor women, but if you happen to be a family practitioner you cannot." Does that make any sense? John, what do you do with your maternity cases?

Mr. EASON. Sir, what we are doing now, we do the prenatal, and refer. If you carry poor people too far, what they will do, they will come and deliver at your site. As I think one of the physicians said this morning, then if something goes wrong they want to sue you.

So what you do, is you try to cover your tracks. I have seen this happen at the hospital. They would tell them, say, "We cannot do it." What they would do, they would go back on the hospital lot, Senator, stay there until the baby is coming, and then you have no choice. They would do us that way at the clinic.

The CHAIRMAN. Well, that is not a very good way to do business, though, is it?

Mr. EASON. No, sir, but people learn the system and they are working on you. I am in agreement with you, just changing the subject, about changing the welfare system. But we are going to have to have some jobs to go along with these things that pay comparably.

The CHAIRMAN. John, how many people did you all run through that clinic last year?

Mr. EASON. We saw I think 14,000 different individuals, but we had about 20,000 to 30,000 what we call "encounters."

The CHAIRMAN. Wanda, what are the hours of most of these public clinics?

Ms. HOGUE. In my nine-county area, it is primarily 8:00 to 4:30, 5 days a week. And they are open through lunch.

The CHAIRMAN. John, what hours do you have?

Mr. EASON. Sir, we start at 7:30 in the morning, and go to 7 p.m. in the evening.

The CHAIRMAN. If somebody has an emergency in the middle of the night in Marianna, what do they do?

Mr. EASON. We usually refer them. We have a system where we tell them go to elsewhere——

The CHAIRMAN. Where do you refer them?

Mr. EASON. We tell them "Go to the nearest hospital."

The CHAIRMAN. Which is Helena?

Mr. EASON. Helena or Forrest City. Let me give you a little scenario. A lot of times it is not an emergency. They will go to the hospital, then they will come back and get their medicine from us Monday, so it was not a true emergency.

The CHAIRMAN. And we have 34 community health clinics in the state now?

Mr. EASON. Access points, yes, sir.

The CHAIRMAN. Access points?

Mr. EASON. Yes, sir.

The CHAIRMAN. We actually have more than that, do we not?

Mr. EASON. No, what I am saying, I think we have some of what we call freestanding clinics, because I heard someone mention what you call a rural health clinic, here this morning. And it may not be, Senator, what we call Federally funded. I am talking Federally funded clinics, sir.

The CHAIRMAN. OK.

Mr. EASON. The freestanding clinics I do not know about. I am talking about the ones that get 330 funding or 329. Down at Hope, we will have our first time getting funded 329, which is what we call a migrant health center.

In Hope, we have a lot of migrants coming through, so this will be their first time in Arkansas, but it will be under the auspices of Cabon Rural Health Center.

The CHAIRMAN. John, Wanda and Ramona, did you know that, under the Clinton plan, these health care alliances are required to contract with these community health clinics? And I can tell you, Betty has visited extensively with Mrs. Clinton about this, and Mrs. Clinton is as committed to community health clinics as anybody; maybe as much as Betty, maybe more so than Betty. I just happen to think it is the finest delivery for the least amount of

money of anything we do. I think the whole thing ought to be expanded.

Now, there are some states that do not even have health clinics, do you know that?

Mr. EASON. Yes, sir.

The CHAIRMAN. Last year we got into a real donnybrook in the middle of the night on an immunization bill. I offered an amendment to say that women on AFDC would be given some period of time, say 3 months, to get their children immunized. Otherwise, they get cut off of AFDC.

Now, you know, Mrs. Clinton did not like it, Marian Wright Edelman did not like it, Betty Bumpers did not like it. They thought that was a cruel thing.

I said, "I cannot think of a more classic case of child abuse than a mama who will not have her children immunized." In addition to that, we had held hearings on one of the subcommittees that I sit on, and found that in Maryland, where they had this program, they went from about a 48 percent immunization level, to 92 percent with this program.

So, you see, it works. That sounds a little bit cruel, but it really works. I was getting ready to say that you have to think differently than the way we have been thinking in the past. In any event, I got that amendment passed that night, and I had to get 60 votes, and I got over 70. I think that that is something that works.

The point I was going to make is that in Maryland, where they have this program, they do not have clinics in Maryland. Every person eligible for Medicaid is assigned a private practitioner, is that not right?

Ms. CHAFFEE. Or an HMO, yes.

The CHAIRMAN. Don Riegle, Senator from Michigan, who is my strongest adversary on this, was saying, "That is all well and good for you people in Arkansas, you know. You are a rural state. But if you are a mama in Detroit and you do not have health clinics, maybe there is one all the way across town, you have got to load that child on a bus. First of all, maybe it is a $2 trip, and you do not have $2, and you have to go all the way across town to get your child to a health care clinic."

I said, "Well, you know, I am blaming you. You are a senator from Michigan, you should have been working on it ever since you got in the Senate to develop clinics, so women did not have to drive all the way across town, or take a bus all the way across town to get immunized."

But, you know, our immunization levels in this country are really much, much better than I thought. Just last week CDC released some new figures. What is it, 82 percent on DPT?

Ms. CHAFFEE. Yes.

The CHAIRMAN. Eighty-two percent. That is an unheard of figure. And this past year, how many measle cases in 1993, do you know?

Ms. CHAFFEE. No.

The CHAIRMAN. I know we went 6 weeks at one time this year without a measles case. In 1990, we had 27,000 cases, and about 32 deaths from measles. That is the reason I keep harping on preventive care. It can be done. We just have to make a commitment.

Ramona, you want to say something?

Ms. TAYLOR. Yes, sir. You know, health departments are not considered community health centers. Yet, in West Memphis I operate as a community health center, in that I provide primary care, and I work in cooperation with East Arkansas Family Health Center. When you made that statement: Yes, I think it is important that we are included in that concept, because some people do not consider us a community health center.

The CHAIRMAN. I know.

Ms. TAYLOR. But it depends on your definition.

The CHAIRMAN. Right.

Ms. TAYLOR. When you discuss immunizations, there is some thought that it is upper income families that do not get their children immunized because they feel they are safe. And certainly a role that I think we could expand on in health care reform is by using health educators doing promotion and prevention activities for the importance, because if your income is in the $100,000 level, you really think your chances are very small of anything happening to your child, but it can and it does. But they forget that, because most of us have not seen anyone with measles or polio. We think it is gone, but it is there.

I do think it is important to remember that we do need some flexibility. Even in the more rural areas, where there are not community health centers, there may be a much more of a need for public health departments.

The CHAIRMAN. I am telling you, I am absolutely committed, under this bill, to expanding the number of community health centers we have in rural areas.

John will tell you that after all the hell we went through with that clinic down there, when we first established it, it is now the primary health care center for just about everybody in Lee County. I want to expand the number of clinics, but I also want to expand what they do.

Ms. TAYLOR. Absolutely.

The CHAIRMAN. Because I think that is where you can save more money than anyplace else. Now, nobody has talked about it, but home health care is covered under this bill, too. Ramona, in your testimony you talked about home health care.

Ms. TAYLOR. Yes, I mentioned home health.

The CHAIRMAN. And, you know, I can remember a little woman who helped us raise our children. She just died last year. She was sort of a surrogate mother to our children. But we kept her out of a nursing home for 4 years by having a woman go by there twice a week to make sure she had taken her medication. And the Meals-on-Wheels program came by, she was not able to go to the Senior Citizens Center for a good, nutritious lunch. They brought the meals to her. Those things cost a pittance compared to what it would have cost to put her in a nursing home.

Ms. TAYLOR. One of the things that I think we did that was excellent in developing our pediatric primary care clinic is, we did not open a government clinic. We offer round-the-clock coverage.

When it is 2 a.m. in the morning, your baby has been crying for 4 hours, it is really a lot more comforting and a lot more sensible to pick up the phone and call the nurse practitioner who is on call, or the physician who is on call, and say, "This is what is going on.

Do I need to go to the emergency room? Can it hold until in the morning?"

I think that is real important when we look at this, that the traditional government clinic be part of the health care community and be held accountable for providing the same standard of care that they do.

The CHAIRMAN. Let me make a closing observation, then we will quit. It is past lunchtime. But I can remember when I was first elected governor, I had been on the receiving end of a lot of rudeness by Federal and State employees, and I put out an edict. I found out later that just because the governor signs an edict does not mean it is going to happen. But I thought at the time it did. I was so carried away with my new position of power, I just thought I could do anything.

I put out an edict saying, "Rudeness will be grounds for firing. Any state employee, particularly in the revenue offices, caught being rude to people will be fired." About 2 weeks later we fired a woman in Booneville, AR, and I can tell you it really had a salutary effect on people's conduct. They thought that was just something I was putting out for political purposes. And it really made an impact.

There is just nothing worse, and particularly if you are poor and you are at everybody's mercy, to be treated like dirt. And it often happens. I went with my daughter to get her driver's license in Maryland, and I found out that was not just something peculiar to Arkansas, too, incidentally.

But the other thing is, people who are sick or troubled and come to these clinic are entitled to courteous, prompt attention. Betty has a heart condition. The other night I had to take her down to the Georgetown Emergency Room at 2 in the morning. And this woman wants to go through a history. Here is Betty's heart beating 200 beats a minute. She is terrified, even though she has had it 500 times since we have been married, she is still terrified when she gets it. Called PAT tachycardia.

And this woman wants to ask me all these questions. I have Blue Cross-Blue Shield coverage. I have everything under the shining sun. And I said, "Listen, I can sit here and answer your questions all night long. You get a nurse out here to take care of her."

She got up and finally, grudgingly went off and got a nurse to come, and took Betty and everything wound up being just fine. But I just thought, "If a United States Senator gets treated that way, you can imagine how the poor folks are being treated."

Mr. EASON. That is for sure.

The CHAIRMAN. So it is inexcusable. And I tell you this story, because when I ran for reelection in 1986, and I was circling the state, I went into a courthouse which I will not reveal the county of, and I went into the welfare office. There was an 86-year-old black woman sitting there. She was so excited about seeing me, and we just had the best conversation, and she was all alone in the reception room. I said, "What are you doing here?"

She said, "Well, they are going to cut off my food stamps."

I asked her why and she said, "They say I have too much money."

And then I said, "Well, how long you been sitting here?"

She said, "Since 9 this morning." And I had already had lunch. It was either 1 p.m. or 2 p.m. in the afternoon.

I asked, "Do they know you are here?"

She said, "Yeah, I told them I was here."

"And you have been waiting for 4 hours for somebody to see you, after they sent you a notice in the mail to be here at 9 a.m.?"

"That is right." Now, I will tell you, that is one time I lost my temper. I went storming through the rear end of that place. I could not believe that anybody could be that insensitive to a woman like that. Dearest, sweetest woman I ever met.

So, as I say, all of us who are at the public trough and the public payroll have a double duty to at least be polite, and to be courteous, and to try and provide the services that we are being hired to deliver. That is the reason I am in Jonesboro today. It is a very good experience for me, and I learn a lot from it, but it also helps people vent their spleen and say what they want to say, and that is all helpful to me, and that is government at its best, far as I am concerned.

Anybody else have a final comment they want to make? Yes, stand up right where you are.

Mr. HURT. My name is Blant Hurt. My family employs about 125 people in this community.

The CHAIRMAN. Yes.

Mr. HURT. My family has three companies here. We employ 125 people. We have been in this community for 30 years. And I want to say that I am very much opposed to this health care plan.

I think a lot of the things that the young lady said today about the disincentives on business are very real. I think if the politicians are not careful—and I really appreciate your coming here today—but there has not been much discussion of the impact on small business.

The payroll taxes, if the politicians keep up, are going to drive the economy underground in this country, and I am very concerned about that. Thirty years from now we are going to have an economy that looks like a Latin American economy, where people pay to do things underground, with payroll taxes, mandates, regulations. But I am very much opposed to the Clinton plan.

I think another thing we did not talk about here today is the coercive element in it. Not only in taxes, but the new health care plan is going to be set up for federalization of crimes, and those are all in the health care——

The CHAIRMAN. Federalization of what?

Mr. HURT. Health care fraud crimes. I think that is something we should all consider.

The subsidies to business: We do not want subsidies. My business does not want a subsidy from the Federal Government. How I feel towards the Federal Government, and I have a small business, is——

The CHAIRMAN. What is the nature of your business, incidentally?

Mr. HURT. My family has a company called Sun Industries. We make tanning equipment. Our factory is not far from here. I would be glad to take you out and show you. We have another company

that makes exercise equipment, treadmills and stair climbers. Another company, my company, that makes electronic signage.

But I was speaking of the subsidies. We are not interested in subsidies from the Federal Government.

The CHAIRMAN. Do you carry health insurance now on your employees?

Mr. HURT. I am sorry?

The CHAIRMAN. Do you have health insurance on your employees now?

Mr. HURT. For some I do and some I do not.

The CHAIRMAN. Do you run all of these businesses now?

Mr. HURT. No, sir, I do not. My father, my uncles and myself run and manage the companies.

The CHAIRMAN. How old is the business? Did your father found the business?

Mr. HURT. Yes, sir.

The CHAIRMAN. How long ago?

Mr. HURT. My father has been founding businesses since the early 1960s, he has been starting businesses.

But my point is that production of wealth comes before distribution. And we talk and hear a lot about the redistributing of wealth. But the needs of producers I am very concerned about, and the disincentives on business, the level of taxation.

Mr. Eason said we were founded on the principle of no taxation without representation, and we have gotten away from that principle. I would point out until the early part of this century we did not even have a Federal income tax. Now, we are talking about more and more taxes. And you opposed the tax cuts in the 1980s.

The CHAIRMAN. I did, and I want that put on my epitaph.

Mr. HURT. Well, I want it put on my epitaph and my tombstone, just as you told those people in Little Rock, that I oppose this plan on moral grounds. You have no right to tax us; production comes before distribution; and it is coercive. We will not stand for it. Small business people will not stand for it. And we want to be heard, and it is wrong.

I appreciate all these things with public health. I completely agree. Benevolence is very important in our society, and kindness towards people. But the question is: Can we have a kind and benevolent society when we are being crushed by our government? History proves that you cannot. The way to have a kind, benevolent society is to give people room for freedom and let them be charitable towards people, as they will be. But this is wrong, and I oppose it, and I appreciate your letting me have my say.

The CHAIRMAN. That is quite all right, and I am glad you are here.

Let me just make one observation. The other day I was talking to my son, who was talking about how much tax he was going to have to pay. He is probably going to wind up in that 36 to 39 percent category. And he said, "I would not mind doing this, but I am paying for all of that nonsensical military spending we did in the 1980s, and at the same time cutting taxes for the wealthiest people in America. I would not mind paying my share to reduce the deficit, except the deficit was created so nonsensically."

So, you are absolutely right, not only did I vote against that tax cut in 1981, I said, about an hour before we voted, "You pass this tax cut, you are going to create deficits big enough to choke a mule. You cannot cut taxes by $500 billion, and increase defense spending by 100 percent, and balance the budget. You would have to take leave of your senses to believe otherwise."

Mr. HURT. I would also say you would have to take leave of your senses to say you can extend universal health care to everyone in this country by a government mandate, and cut health care spending, just as you said. Now, if you are going to be consistent, where is your consistency? That is completely illogical. And in my opinion, you are playing party politics, and I applaud——

The CHAIRMAN. Look, I am not committed to this. That is the reason we are here, to talk about the bill and the impact it is going to have on small business.

Mr. HURT. I would strongly encourage you to bring the same scrutiny to bear on the impact on Federal deficits. And also——

The CHAIRMAN. I promise you I will.

Mr. HURT. And also keep in mind that when Mr. Wilbur Mills' committee projected Medicare spending into the 1990s, he missed it by a factor of ten. The government's history of projecting these expenses do not give me a great comfort level.

The CHAIRMAN. Do you believe in student loan programs?

Mr. HURT. I do not believe in any government, aside from protecting our borders, having an objective court of law, and that is about it.

The CHAIRMAN. Do you believe in health care for poor people who cannot afford it?

Mr. HURT. I most certainly do, and I think if we had a health care system where the government was out of the system, we would care for far more people at a far better level than we ever will——

The CHAIRMAN. Well, you and I have a lot of basic differences,——

Mr. HURT. I know we do.

The CHAIRMAN. —and it would take us a long time to resolve them.

Mr. HURT. I know we do.

The CHAIRMAN. But, you are welcome here, and I appreciate your comments.

Bobby? Sure.

Mr. HOGUE. I am Bobby Hogue, State representative here, and I serve on the Public Health, Welfare, and Labor Committee. I also serve on the Agriculture Economic Development Committee. I am a member of the Health Resource Commission, which will probably have the responsibility of implementing whatever health care reform package that comes down in the State of Arkansas. I am also a member of the Executive Committee of the Health Care Task Force of the American Legislators for Change Council.

So in the last year and a half I have had quite a bit of exposure to health care reform. And, needless to say, I agree with your assessment that whatever you all pass, the states are going to have the responsibility of implementing.

I, too, have a concern with any new Federally mandated programs. I look back at Medicaid, of course, which is the last Federally mandated program that we have. In the State of Arkansas, as you well know, in 1992 and 1993 we spent $912 million on Medicaid.

The CHAIRMAN. How much?

Mr. HOGUE. Nine hundred twelve million dollars, which was a 152 percent increase since 1985.

The CHAIRMAN. In one year?

Mr. HOGUE. In one year, $912 million.

The CHAIRMAN. The State of Arkansas spent that much?

Mr. HOGUE. Medicaid.

The CHAIRMAN. Well, you are talking about the State and Federal share, both, the total?

Mr. HOGUE. That is a total amount.

The CHAIRMAN. Yes.

Mr. HOGUE. Total amount. And, of course, which, as I say, was 152 percent increase since 1985.

As you well know, 2 days after Governor Tucker took office, we had to have a special session to increase taxes on the people in the State of Arkansas to keep our Medicaid program from going in the red. We increased one of those, which was a soft drink tax, which people do not believe this, but was going to cost us 150 jobs here in Jonesboro, because sooner or later the Coke plant is going to completely move out. We have already lost a lot of them, but we are going to lose the rest of them.

My only concern to express to you all is that, I question whether or not we want to turn something like this completely over to the government. You are a prime example of this, because when you were governor you made some tremendous changes in the way the system worked in the State of Arkansas, which was for the best.

The States are the laboratories. And by President Clinton's emphasizing health care reform, and by what you all have done, you have been the catalyst for the States to make some changes, which is going on right now, and a lot of States have had some major changes. In the State of Arkansas, we are looking at a lot of different things. We have put in a gatekeeper program for the Medicaid program, which we think is going to save some money.

I have also presented the Governor and Tom Dalton a copy of a bill that would privatize the Medicaid program. Whether or not we proceed with that, we will not know.

The CHAIRMAN. Bobby, are you talking about something like I talked about for Maryland?

Mr. HOGUE. Right. And I am in the insurance business. People say, "Ah-ha, here is where you are coming from." I do not market any health insurance. It will not affect me, whatever happens to the health care reform.

But I have visited with a lot of small business people, and I visited with Bob Wimbly, with the National Independent Federation of Businesses here. And they tell me, without a doubt, that it will cost somewhere in the neighborhood of 150,000 jobs in the State of Arkansas, simply by people downsizing their businesses because they have to pay for health insurance. That is probably some of them that do not provide it now.

What I am ending in saying is that, if you will, give the States considerable say in this; but, at the same time, do not put Federal mandates on us again that we have to turn and fund completely from the State level, or a lot of it from the state level, because I look at these programs and I simply see that the Federal programs are always much more costly than they are projected to be.

I honestly think that if we do not get Medicaid under control in the State of Arkansas, I think it is going to literally break the state. I know it is considerably worse in other States. We are not the worst, by any means. But that concerns me, with having a Federally run program, as this would be in turning everything over to those alliances and that kind of thing. I think it would be much more complicated than it probably is now.

The CHAIRMAN. Yes. Do you sell health insurance, Bobby?

Mr. HOGUE. No, sir.

The CHAIRMAN. I tell you, one of the things that you do have to think about is, you know, there are literally tens of thousands of people in this country who are selling health insurance and engaged in the business.

Mr. HOGUE. Sure.

The CHAIRMAN. And there is just not much left for them.

Mr. HOGUE. It will cost those people some jobs.

The CHAIRMAN. Yes. Well, there is not any question but this is a very dramatic change; a lot of people are apprehensive about trying to change the health care delivery system so completely in such a short period of time.

Mr. HOGUE. I am concerned. I think small business people created this country, and I think they are the backbone of this country. To me even in Jonesboro, we have a tendency to want to attract out-of-state industries, and not do much for the existing industries. We want to give a tax break to the people who come in, but we want to tax the people who are already here.

So I agree with you that the small business people are the backbone of this country. They are having an awfully hard time staying in business today, with additional taxes and regulations. So, I would like to see us certainly keep those people in mind.

The CHAIRMAN. Bobby, I want to put one thing in the record here—if I can find it here. Well, this is it.

[Reading.]

The CHAIRMAN. "All of the growth in our economy since 1980 has come from smaller, often newer companies. Between 1988 and 1990, firms with one to 19 workers——"

You think about this. Between 1988 and 1990, that is a 3-year period, "—firms with 1 to 19 workers gained a total of 4,016,000 jobs—new jobs, while those with more than 20 workers lost 1.36 million jobs." So you can see where all the new jobs are coming from. You cannot enter into something like this without thinking about what impact it is going to have on all of them.

I might also say that one of the reasons big business is downsizing, and every day, when you pick up The Wall Street Journal you see where Gillette and somebody else is cutting 2, 4, 5, 6,000 employees, and one of the things that big business is learning in this country, and that is that in order to stay competitive with Japan and Germany and everybody else we have to compete within the

world market, they have found out they can get by with fewer people. And they are getting by with fewer people.

I guess that is free enterprise at its best, becoming more and more efficient. That is one of the reasons for the job losses in 1988 to 1990 in the bigger businesses. But, by the same token, the point I want to make is that small business is sort of the business that makes the mare go in this country.

Thank you all very much for being with us, and thank all of you for attending this morning.

[Whereupon, at 1:20 p.m. the hearing was adjourned.]

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HEALTH CARE REFORM

FRIDAY, JANUARY 21, 1994

U.S. SENATE,
COMMITTEE ON SMALL BUSINESS,
Fayetteville, AR.

The Committee met, pursuant to notice, at 10 a.m., at the Law Building, Room 113, Arkansas State University, Fayetteville, AR, Hon. Dale Bumpers Chairman of the Committee, presiding.

OPENING STATEMENT OF HON. DALE BUMPERS, A U.S. SENATOR FROM THE STATE OF ARKANSAS

The CHAIRMAN. I know that many of you have taken a great deal of effort to write very thoughtful statements this morning. I might say to all of you I have read all of the testimony that we have received.

I am very impressed with the thoroughness with which some of you addressed the problem. In any event, I want to thank you. I would be remiss if I did not at this point thank the University of Arkansas and the law school, in particular, for allowing us to use their moot courtroom here today for this hearing.

Having said that, I will make just a few extemporaneous comments, to sort of lay the foundation for the purposes of this Small Business Committee hearing.

This is the third hearing that the Committee has held in Arkansas, and we will hold as many as three more hearings in the Small Business Committee in Washington, where witnesses from all over the country will come in to testify.

It does not make any difference where you hold these hearings because I think the testimony from the small business people would generally be about the same. What we have heard so far is that, "I hope I can afford it." From those who already offer health care coverage to their employees, they are a little more sanguine about the future than those who do not carry it, and feel that it is going to be such a burden they might even have to shut their doors.

While our primary emphasis is on small business and the impact that the President's proposed bill is likely to have on them, we would be remiss, and certainly I would be almost derelict if I did not try to also educate myself on what providers and consumers have to say about it.

People are becoming increasingly educated on the subject. Sister Judith Marie, in your testimony you talk about universal coverage, preexisting conditions. In our society, for somebody to be denied coverage because they have a preexisting condition seems to me is

at cross-purposes with what we ought to be doing as a civilized Nation and a compassionate Nation.

Second, I think everybody would agree that we must have universal coverage. But we have to figure out some method, even at the expense of cutting back on the basic package, to cover everybody. As a matter of fact, we are essentially covering everybody now, and those who are covered are essentially paying for those who are not covered.

One of the things the President says constantly—and I am not sure he is right about this, I think he is partially right—is that he believes that there is going to be great savings. And that is because people who are covered right now are paying increased premiums to make up for the increased cost of providing health care coverage at the hospitals and in doctors' offices. They are paying higher premiums to take care of the higher costs that they have to charge in order to take care of those who are not covered.

I am not sure we will accomplish the savings that the President is proposing on Medicare. We have cut Medicare just about to the bone. I do not see how we can get much more out of it.

But, then, we are talking about roughly $50 billion in savings that will help pay for this plan. We are discussing a cigarette tax, and a booze tax—the sin taxes. Nobody can say with any degree of certainty that the President's financial plan on this is going to work. There is some who say it will and some who say it will not. So you can have your choice.

Freedom of choice for selecting a doctor is a big issue with a lot of people. If you were going to have neurosurgery and you lived in Charleston, AR, but you maybe thought that there was a better doctor in Boston that you would like to perform the surgery, under the present proposal you would not be allowed to go to that doctor unless you were willing to pay for it yourself.

There would be what is called a gatekeeper making that decision for you. Some people take strong exception to that. But I think universal coverage, doing away with preexisting conditions, freedom of choice of doctors, are a few of those things that are basic that must be incorporated into any plan we adopt.

As I have said, my primary concern is the impact this reform is going to have on small businesses. There are roughly 66,000 businesses in Arkansas, and of that number, 62,000 plus are considered small business. So what Congress is going to have to do, and the Small Business Committee will have considerable input into, is to determine: Are all these benefits and all these goals that we would all agree that a civilized Nation ought to be trying to accomplish, are they worth putting maybe several hundred thousand small business people out of business? Or should we try to accomplish those goals and rework the small business part of it so that, while it might be a tremendous burden on some, it would not actually put them out of business.

Most of you here know these things without me saying them, and that is that it is an immensely complex issue. I have been in the Senate now for 19 years. In this era of anti-incumbent and term limits, I am always reluctant to say I have been in the Senate 19 years, but I have. There is no denying it. And in the 19 years I have been there, I do not think there has ever been an issue,

maybe short of the Gulf War, that presents as much of a dilemma to the Congress.

With that, let me again thank all of you for coming. We have our first panel seated here, Robert Vining.

Do you go by Bob or Robert.

Mr. VINING. Bob.

The CHAIRMAN. Bob Vining, owner, Ozark Imports in Springdale. Kanna Phillips, owner, First Choice Realty, Clarksville, AR; Jason Cole, co-owner, Professional Therapy Services, and Razorback Sports and Therapy Clinic in Fayetteville; and Jo Kelley, CEO, The Razorback Federal Credit Union in Fayetteville.

Bob, your name is first on the list, so please proceed.

STATEMENT OF ROBERT VINING, OWNER, OZARK IMPORTS, SPRINGDALE, AR

Mr. VINING. As everyone heard, I own a small repair facility in Springdale. We have been there since 1975 when we started as a one-man shop. We now have five employees, and we have a new man starting Monday. Last year our payroll was $145,000.

We do pay 100 percent of our employees' insurance. Now, we do not pay for their dependents, but we pay for our employees. With the President's health program, as I understand it, our premiums might possibly go down, but I am still opposed to it. I do not want someone telling me this is the way I have to do it. There are more and more controls, and more and more areas of our freedom are being cut down.

Using a personal anecdote, my wife has multiple sclerosis and she has been without insurance for years, but we cope with it. Multiple sclerosis is not one of the diseases that creates high hospitalization bills, it is a gradual debilitating disease, but still it is something that is considered uninsurable. I think that needs to be addressed, but I do not know how.

As a business owner, I look at some of the vehicles some people drag in, and I just shake my head and I say, "No, I do not want to touch that car, because it is going to be a vehicle that we cannot successfully take care of." And if I were an insurer, I would probably want to have the freedom to make some choices that way. I do not have answers, I have lots of questions.

I have concerns with the Clinton program, because even though my cost might go down initially, I think the long-term cost to the employer is going to increase. I know that the cost will increase to my employees, because I am now paying 100 percent. In the proposed plan they would be required to pay 20 percent. So, their cost is going to go up.

I am also concerned about the amount of paperwork that will be required to meet all of their regulations. As I understand it, employers will be reporting monthly to the alliance, as to any changes that go on at all with our employees.

Another thing that I am concerned about is, if our alliance comes up short at the end of the month or at the end of the year, they do not have to worry about it, they just reassess us. As employers, we would then have to make up whatever the shortcoming is.

I would love to have a company that I could do that with. I just do not believe that this is the way it needs to be run. Because the alliance would have no incentive at all to operate efficiently, to try to do things to the best of the employer or of those with insurance.

Another concern I have has to do with the proposal having been called a Blue Chip or a Fortune 500 insurance benefit package. If we are going to make this universal coverage, should we not make, for want of a better term, a bare bones type coverage that is universal? Then as a self-employed person or as a professional or any other area, if you desire a higher degree of insurance, then you are allowed to pay for this extra. Have it progress in steps. The first lower step is guaranteed universal coverage. Then allow each individual if they want to, contribute more and purchase the next higher level.

As far as the cost savings on universal insurance, it is supposed to decrease our insurance costs. Arkansas has a requirement that all automobiles have liability insurance. How many of us have actually had a decrease in our insurance premium? It has not happened. So I have very serious doubts as to that happening on our hospitalization.

The CHAIRMAN. Bob, thank you very much. If you will, just stay seated and we will have a few questions in a moment. Mrs. Phillips?

STATEMENT OF KANNA PHILLIPS, OWNER, 1ST CHOICE REALTY, CLARKSVILLE, AR

Mrs. PHILLIPS. I support a universal health insurance plan. However, I am very opposed to small business being assessed 7 percent of their gross payroll. I think that this will close the doors of many small businesses. I think that they are operating on about as small a margin now as they can.

I just returned from a trade show in Dallas, where there were 1,200 small business exhibitors, and about 30,000 buyers and spectators. I took this opportunity to talk with these small business people, because I was down there with others who were buying. Most of them did not feel that they would survive for a long period of time with any more added cost to their businesses.

I understand that this plan is suppose to reduce your health premiums. At the present time we pay all of our employees' health——

The CHAIRMAN. How many employees do you have, Mrs. Phillips?

Mrs. PHILLIPS. Well, we have 5 different businesses, and we have 21 people in those 5 businesses.

We have a Blue Cross-Blue Shield family policy with a $200 deductible. For that we pay $537.98. We pay their life insurance, which is $34.30, and we carry a major illness plan, which is $30.66, for a total of $605.94 per month, per employee, for their insurance. And we carry this major illness, because if you have a major claim with Blue Cross-Blue Shield, their premiums go so high so fast that you just cannot afford a major claim. We had a 90-plus thousand major claim in 1992 on this major illness, and with no premium increases.

I think a covered individual should pay part of their coverage, because if a person is paying part of their coverage, they tend to seek cheaper medical services than if they were just on a no-fee, no-plan.

I also think that the people who are going to pay part of their coverage should be able to pay it possibly out of their IRAs or their 401K plans. Maybe not wait until they are 59½ to use those. If they could use those to pay their medical bills, I feel that would give the person more of an incentive to pay his bills. I think that as long as they have some means of being able to pay it, and know that they can pay it.

I think if they do not have to pay any, there will be the same abuses there is with Medicaid. I serve on the hospital board at Johnson County Regional, and I take time to go up there sometimes and visit with these people sitting in the emergency room. And they are there for colds, fever.

I ask them why they do not go to the clinic for this care, because it would cost half as much, or less than half as much. And they say, "It does not cost me anything, anyway, so I do what is best for my schedule." I think if a person has to pay for their coverage, they are more careful with it.

We also need to guarantee that people living in rural America have access to health care 24 hours a day. Rural health needs the airlift service, if necessary, 24 hours a day. And I support a cap on malpractice. I think that would reduce our health coverage a lot.

The CHAIRMAN. Support a what on malpractice?

Mrs. PHILLIPS. A limit on what people can sue for on malpractice. I think there should be a schedule, like there is on surgery for your insurance. Say if you sue for malpractice and win, you can only get so much—there should be a cap. I think that would decrease the cost of health coverage by at least a third.

I think that when there is universal health coverage, the premiums that we now pay to Blue Cross-Blue Shield, or whatever, will have to be reduced, because now a person who is insured will pay three times the amount for covered charges because they are being charged to cover those who cannot pay. Every time you have a larger bill and pass it on to your insurance, that is why premiums keep going up.

If there is universal coverage, if everyone is covered, that will keep the cost of insurance from going up so much. When the abuse and the fraud is taken out of health care as we know it today—mostly the abuse—I think that cost of health care will be reduced a great deal.

The CHAIRMAN. Thank you very much, Mrs. Phillips. Mr. Cole?

PREPARED STATEMENT OF KANNA L. PHILLIPS

I support a universal health plan, however I strongly oppose small business being assessed 7 percent of gross payroll to cover the cost of this plan.

Most small businesses are struggling to keep their doors open and being forced to pay 7 percent of gross salary to health care would cause many of them to close their doors forever. If the employees were to pay this 7 percent I would support it.

I just returned from a trade show where approximately 3,000 small businesses were exhibiting and had some 30,000 in attendance. After talking with some of these businesses about their future many had doubts about their long term survival.

As I understand action 93 is to limit insurance premiums, I strongly support this. At the present time we pay the following for employee insurance coverage:

Blue Cross and Blue Shield ($200 deductible per family)	$537.98
Life Insurance	$34.30
Catastrophe	$30.66
Total per family per month	$605.94

We carry catastrophe in case we have a claim in excess of $90,000. If such a claim was ever made our premium would raise to a point that we could no longer afford it. We had a claim of this size in 1992 so the necessity does arise from time to time.

In my opinion each covered individual should be charged a premium for the coverage. They would then feel more obligated to seek the least expensive treatment.

Some medi-cade recipients will wait until evening to seek treatment at an emergency room instead of waiting their turn at a clinic. This doubles the treatment costs but doesn't cost them any extra. It also allows them to stay at home through the day so they don't miss any daytime television.

I understand action 93 is to guarantee treatment in the rural area 24 hours a day and access to airlift service. Also action 93 will allow you the privilege of using your IRA and 401K (without penalty) to purchase health care, this will be an advantage to many.

I also strongly support a cap on the amount awarded in a malpractice suit. This could reduce health care by ⅓. Also when everyone is insured it will reduce the fees charged for the presently insured patient. At the present time we are charged three times more than actual expenses to cover the uninsured debt.

When fraud is eliminated from health care a milestone will have been reached.

STATEMENT OF JASON COLE, CO-OWNER, PROFESSIONAL THERAPY SERVICES & RAZORBACK SPORTS AND THERAPY CLINIC, FAYETTEVILLE, AR

Mr. COLE. I am kind of in a unique position here today, Senator Bumpers, because I am a small business owner, and my business is providing health care. I am a physical therapist and have been in private practice in Fayetteville for 25 years.

In my business, our insurance premiums have risen considerably in the past 7 years, and because of the cost we have increased our deductible from $100 to $1,000 per year.

For instance, 7 years ago, with the deductible at $100 for our 35 employees and their families, our premium was $60,000. The insurance company that we use justifies our premium increase based on our utilization, and the money that they spend on our group. We currently pay 100 percent of the premium, which is now $90,000 per year. We cannot change insurance companies, because within our group we have some preexisting conditions that other insurance companies will not accept. We do not invest in a profit sharing plan or retirement plan, but instead we have used our profits to grow.

Our growth is currently stymied due to these proposed health care issues and its potential impact on our business. We have bought land to build another clinic, but we will not start construction or begin proposed additions to our other two clinics until this health care issue is decided, and our future can be somewhat certain.

In the back of our minds, we feel that we may be going by the way of the family farm or the mom and pop store, and not so much because of the premium of health care, but because of what our involvement in future health care may be.

The problem with our policy and with other insurance policies seems to be that the benefits turn out to be an ill-defined subject that is budget related. Therefore, we find that you must call the insurance company prior to any diagnostic testing or hospital admission to see if they can be approved, and we feel that is probably to see how much money is in the account.

The result is that we now find that some insurance companies no longer pay for hospitalization the night before surgery, they have cut payments to providers by 10 to 30 percent, and pay for fewer diagnostic studies, while the premium remains the same.

Insurance companies, on the other hand, are required to pay hospital room rates and professional fees that reflect the underpayment of Federal insurance programs, and increasing non-patient care responsibilities relating to paperwork and legal intervention.

We, as providers, accept assignment, which means that we take whatever payment amount the insurance company and government insurance plans feel is justified, and they pay 80 percent of that amount. The patient is then required to pay the other 20 percent, unless we can bill their co-insurance company.

Medicare has a $900 cap per year on the services that can be provided to each individual at our clinics. These fees are subject to denial of payment, even though the physician feels the treatment is necessary. The complications of the system require one patient admission person in each clinic to assist patients to fill out the necessary information, and explain their insurance coverage to them.

No one will deny that the medical system needs some revision. The type of revision depends on who you talk to. Health care workers see the problem as too much paperwork, legal intervention, uninsured patients, uncovered services, restricted government program reimbursement, and less time to spend with the patients due to these factors. Health care workers are also working in a high risk environment.

The public and the government sees the problems as too much expense, and too many uninsured people. Some of the high expense of the system is in the area of workman's compensation and liability cases, which are both heavy into legal intervention.

There are several Federal and state programs that our clinics provide service for. One is Medicaid, which will cover patient treatment in the home for up to 12 visits per month, but currently does not cover anyone over 21 years of age. These patients need not be homebound. This results in patients being seen in the home that could better be served by being seen in the clinic. Home health services have an approved charge to Medicare of $90 to $100 per visit for physical therapy, while the same visit, without the bureaucracy of the home health service, would be $50.

More money is spent on the management of the Medicare system than is spent on patient care. When we do work for the Arkansas Rehabilitation Agency, they seem to always be short of money to provide the prescribed service.

The current health care system is resistant to new techniques of patient care that are more effective and less expensive. I have two examples that fit that category. The Federal and State governments survey hospitals, rehabilitation agencies, and home health

services. Their surveys are paper-oriented, with no emphasis on outcomes or patient satisfaction.

In closing, let me say we often look to Canada and their health care system, and it must be remembered that many Canadians come to the United States for health care. In Canada this past December the hospitals were closed due to lack of money in the system, and only emergency care was provided during that time.

The CHAIRMAN. Thank you very much. Ms. Kelley?

STATEMENT OF JO KELLEY, CEO, RAZORBACK FEDERAL CREDIT UNION, FAYETTEVILLE, AR

Ms. KELLEY. Thank you for allowing me to share my concerns. I feel it is important for all citizens to have quality health care coverage that will continue, despite a job loss, a job change, or a chronic illness. I would like to see some type of managed health care organization in northwest Arkansas made available to all citizens, so that they may have quality health care at a reasonable cost.

I am a manager of a small credit union that serves the employees of Standard Register Company and Kerney Company, and we have assets of $1.6 million. I am concerned that any plan that would require all employers to provide insurance benefits, regardless of the number of employees would have a strong impact on us. The cost for one employee could be as much as one-third of our compensation, while it would be one-half or more for a single parent. It would be almost impossible for a credit union of our size to meet that expense.

Personally, I have been fortunate enough to be covered under my husband's insurance plan, which pays 90 percent of our incurred expenses, with a relatively low deductible. However, if I were to lose my husband I would have to ask my credit union to provide insurance coverage for me and my son, or I would have to look for a job where we would be covered.

Similar situations exist in over 50 percent of Arkansas' 96 credit unions. If it were not for health insurance coverage from another source, most of the people employed by these credit unions would not have health insurance coverage.

Currently, the cost of coverage is a major factor that keeps employee health plans from being offered in most of these small credit unions. If such coverage were mandated, the cost would, in some instances, force the closing of the credit union; or, at best, increase our loan interest rates or otherwise reduce the levels of service that we provide.

Such a program would ultimately have an impact on 15 percent of the 200,000 plus members of Arkansas credit unions because, although the majority of people belong to big credit unions in larger cities, 15 percent of credit union members belong to credit unions that are in outlying areas, who would otherwise have less opportunity to have financial services close to their home.

On the other hand, the lack of health care benefits affects credit unions' ability to attract and retain qualified employees, especially those who are unmarried, or who are single parents. There is considerable cost involved in training new employees in small busi-

nesses, with constant turnover of employees because they are always seeking better insurance benefits. I would like to see some provision in the plan to help small business provide the best possible insurance benefits in order to attract and retain quality employees.

I appreciate the opportunity to express my concerns as the manager of a small credit union, as well as on behalf of other smaller credit unions. We are all concerned about quality health care, and we hope that a workable solution will be found.

The CHAIRMAN. Thank you very much.

The CHAIRMAN. Mr. Vining, you say you pay all the premiums on your employees, is that correct?

Mr. VINING. That is correct.

The CHAIRMAN. How many employees did you say you have?

Mr. VINING. Five. And a new one starts Monday, so we will have six.

The CHAIRMAN. That is how many employees I had when I was in business, so I really relate to that. But as you know, under this bill, your employees would be required to pay 20 percent.

Mr. VINING. Right.

The CHAIRMAN. There is talk of requiring, in some instances, employees to make a bigger contribution to lessen the impact it would have on small business. Now, in your case, just to be perfectly crass about it, in a sense this would be good for you, would it not, if your employees had to cough up 20 percent?

Mr. VINING. Sure, the plan, as I understand it now, would decrease my cost. I have so many concerns about the other portions of it, that I cannot, in good faith, support it as I see it now.

As far as the increasing costs and it driving small businesses out of business, I have serious doubts of that, because small business people are survivors, by nature. I mean, what we will do is pass the cost on to our customers. If it is a universal type plan and everybody has to do it, then everybody's cost goes up. So who winds up paying for it in the end? It is the consumer. And that is the way it always is.

The CHAIRMAN. But you would agree that some people would have a much easier time passing on this increase in cost than others? It depends on the competitiveness of their particular business, does it not?

Mr. VINING. Well, it depends on the competitiveness of the business, true. If you have an equals sign here and you add to both sides of it, it is still equal. That is the way I would see that part of it.

The CHAIRMAN. Yes. What kind of deductibility does your plan have?

Mr. VINING. Two hundred dollars.

The CHAIRMAN. Do you know or have you explored with your carrier how much you could save if, say, you have a $1,000 deductible? Mr. Cole, was it you who has a $1,000 deductible?

Mr. COLE. Yes, sir.

Mr. VINING. Yes, I have discussed it, and it is not a very substantial decrease in our premium.

The CHAIRMAN. It is not?

Mr. VINING. No. We have explored using several other carriers. But, like one of the other panelists said, we had one gentleman with some preexisting conditions, and it really would be difficult to change to another coverage.

The CHAIRMAN. In your opinion, is your policy a good one? Is it more a Cadillac than it is a Model-T version?

Mr. VINING. It is upper middle level, I would call it.

The CHAIRMAN. I think you may have mentioned something about a bare bones policy. So that everybody is on the same wavelength and we are not ships passing in the night here, and we all understand what we are talking about. As you know, we will have alliances, and the legislature will dictate how many alliances we have within the State of Arkansas, but just let us assume we are going to have one. That is the common perception. And this alliance is going to be obligated to come up with, precisely what you said, a bare bones package. Now, it is probably going to offer less in coverage than the policy you now have on all of your employees, which incidentally will not make them very happy.

Mr. VINING. True.

The CHAIRMAN. But, by the same token, this is one way we can limit the cost of this plan to the government. It is one way we can limit the cost of it to people such as this whole panel.

This is easier to talk about than it is to implement. But people who are going to testify, the doctors and the administrators, are going to tell you that when you start talking about what is a bare bones package as compared to a Cadillac version, you can say, "Well, we are not going to pay for any breast implants, hair transplants, face lifts, liposuction, and that sort of thing." That is easy. Most of them do not cover that anyway.

But when you start trying to figure out what is elective surgery; you know, what is elective to you might be life threatening to me, or at least I may feel that it is. And we had a gynecologist over in Jonesboro testify, for example, about hysterectomies.

A doctor might say, "Well, go home and live with the pain, the bleeding, or whatever. We do not cover that. That is elective." You can live with the pain, but it is not much fun.

But I think we will cut the policy as much as possible. Incidentally, insurance agents in this country are very apprehensive about this. This bill, if it passed right now, would put them out of business. You are talking about probably hundreds of thousands of people who sell health insurance.

But, if you have this bare bones package, these carriers would be in the business of selling something in addition to that policy, like Medigap right now. As you know, most people who have Medicare also have Medigap to take care of the deductibility and so on.

One of the things you can do, of course, is to limit catastrophic illnesses. But that would sort of render the whole thing moot, too, would it not? Right now one of the biggest problems we have is what is called "cherry picking."

Insurance companies who have your insurance, or any of the rest of you who have your insurance, and let us assume you all of a sudden have somebody in your company with AIDS or terminal cancer, and the carrier comes and says, "Look, you have a choice. You can accept a 100 percent increase in your premium or kick

these two people off the rolls. Those are your options." Well, neither one of those are very good options.

And, I did not mention this earlier, but one of the things that I feel is absolutely essential about any plan is that we stop that "cherry picking" business. When people have a catastrophic illness, that is when they really need insurance.

That is like when my father paid Social Security all of his life and got killed in a car wreck and never drew a nickel back. The reason you carry insurance is because when you need it, you want it.

Well, we are just speculating, but I can tell you there will be amendments offered to the President's proposal to make employees pay more than 20 percent; there will be amendments offered to raise deductibility, to provide that deductibility must be $1,000 or $500 or some such figure. We will even get into the business of what the package ought to look like before approving the package.

I thought all of you spoke extremely well about your apprehensions, and about your own policies. You are to be commended for carrying it.

Now, Mrs. Phillips, you say that you are contributing $605 a month?

Mrs. PHILLIPS. Right.

The CHAIRMAN. And you are paying all of that?

Mrs. PHILLIPS. Right.

The CHAIRMAN. And your employees pay nothing?

Mrs. PHILLIPS. Nothing.

The CHAIRMAN. So the same thing would apply to you. Actually, if your employees had to pay 20 percent, it would save you money, would it not?

Mrs. PHILLIPS. I guess it would save me money, but I would have to raise their wages so they could pay their insurance, so it really would not be——

The CHAIRMAN. So you would not be any better off?

Mrs. PHILLIPS. I would not be any better off.

The CHAIRMAN. Is that what you would do?

Mrs. PHILLIPS. Yes.

The CHAIRMAN. You would fully anticipate raising wages? Would you, too, Bob?

Mr. VINING. Certainly.

The CHAIRMAN. But you said in your testimony you do favor employee contributions.

Mrs. PHILLIPS. We just never had employee contributions. We have always covered their health benefits and their life insurance. If they have to suddenly pay a 20 percent contribution, I would have to raise their wages to pay it.

The CHAIRMAN. You raise an interesting point about allowing employees to withdraw from their IRAs for medical bills. I am not a tax expert, but I think they have the right to do that now, do they not?

Mrs. PHILLIPS. But you have to pay a penalty, a 10-percent penalty.

The CHAIRMAN. No, I do not think so.

Mrs. PHILLIPS. Not to pay for that?

The CHAIRMAN. No, I think that is one of the things you can withdraw from IRAs, penalty-free. I am not sure. I know I voted for it and I think it may have passed. If you are a first time home buyer, you can withdraw your IRA without penalty to put money down on your first home. I think you can also take it out for medical reasons without penalty. I think that is the law now, but I was interested in your observation. Mary Ann, do you know the answer to that?

Ms. CHAFFEE. No, I do not.

The CHAIRMAN. You mentioned malpractice also, Mrs. Phillips. When the President and Mrs. Clinton first started talking about this subject, they said there would be a malpractice provision. There is not one yet, but it is my understanding it is still under consideration. There's also ongoing discussions as to how worker's compensation is going to be treated.

Now, if you talk to the ordinary small business person in this State, they are a lot more concerned about their worker's compensation premiums than they are about their health care premiums.

Mrs. PHILLIPS. A lot of the small businesses are going to management companies——

The CHAIRMAN. I know.

Mrs. PHILLIPS. —because their workman's compensation has gotten so out of balance, that they are going to management companies.

The CHAIRMAN. I do not much like that solution, but I can certainly see why small businesses are doing it.

Mrs. PHILLIPS. Especially in the lumber industries. I know some in our county have gone to management companies, because if they have one accident their workman's compensation goes to something around $70,000.

The CHAIRMAN. Mrs. Phillips, you made another interesting observation. Of course, you and Betty Bumpers are kindred spirits on this point, and that is using clinics more.

Mrs. PHILLIPS. Right.

The CHAIRMAN. You said, "Why would you go to the hospital at night instead of going to the clinics?" And I might answer that in this way—because I am certainly inclined to agree with you on this—number one, the clinic hours usually are from 8 a.m. to 4:30 p.m. Working people have a very difficult time getting to clinics because their hours are not suitable.

Mrs. PHILLIPS. Most of the ones I have talked to do not work or do not——

The CHAIRMAN. You are talking about the people who are at the hospital who could have been there all day, anyway?

Mrs. PHILLIPS. Right.

The CHAIRMAN. I am sure that is true in some instances.

The second thing is: A lot of clinics are limited on what they can do. For example, if you have 101 degrees of fever and you go to the clinic, they are just going to say, "Go to the hospital."

If you are bringing a child in to be immunized, that is fine, they will immunize your child. And it might be that if you are in for a sore throat, but you do not have a fever or any indications that you might be getting into some difficulty, they might be able to treat that.

We have 34 federally funded clinics in Arkansas in what we call access points. I happen to be a strong believer in those clinics, because ever since I was elected governor of this State, I have been concerned with primary health care, and how you get into the primary health care system.

I am a fine one to talk and I should probably not say this out loud. I do not have a doctor. And I do not know right now what I would do if I had an illness, because I do not know a doctor to call.

And you might be surprised to know that about 50 percent of the people in the United States fit in this category. They certainly do not know what they would do in case of an emergency. If they had time to think about it, they would probably figure something out.

Mrs. PHILLIPS. Yes, but I think an emergency is one thing, and just a regular doctor visit is something else.

The CHAIRMAN. But my point is this, and I certainly recognize the merit of what you are saying. Oftentimes people do have conditions that clinics are not capable of treating.

So, not only do we need more clinics in rural areas, we also need to broaden the scope of the kind of things they can do. Right now the medical profession is very upset, at least the members of the American Medical Association are, about the increasing responsibilities that nurse practitioners are getting.

Now, nurse practitioners are a step beyond RNs. I personally think that that is one place where we could save an awful lot of money in this country, by using nurse practitioners more widely. But we will hear more about that from some of the others later on.

You mentioned malpractice. I will tell you precisely what malpractice costs in dollars; 1 percent.

Health care costs in this country are going to run about a trillion dollars. Right now, a family of four spends 16.7 percent of their income for health care. That figure is heading toward 20 percent by the year 2000.

Now, we cannot sit idly by and let this happen. This is painful for everybody. I wish this whole thing would go away. I wish I did not have to be in Fayetteville today to even talk about it. But the truth of the matter is, everybody feels that something has to be done with the health care system, and everybody knows that when we are spending something like 14 percent of our income for health care, nationwide, and no other country on earth spends more than 9 percent, there is something seriously amiss.

Malpractice, in a trillion dollar economy, represents $10 billion. Malpractice is probably not as big a culprit, from a premium standpoint for doctors, as it is for what we call defensive medicine, where they prescribe all kinds of treatments to make sure that, if they do get sued, they have taken every precaution to do everything that any prudent and reasonable doctor would do under the circumstances. Well, we could talk about that for a long time, but——

Bob, do you want to comment on that?

Mr. VINING. I just have a question, and this is due to ignorance and not being in that field. But when you and I were youngsters and we had an illness——

The CHAIRMAN. That has been a long time ago.

Mr. VINING. Yeah. They still had doctors. We went to a family doctor, and he took care of everything.

You were mentioning that if you go to a clinic and you have got anything more than just a runny nose, they probably will not treat you. Is this due to lack of qualifications at the clinic, or is this due in part to fear of malpractice?

The CHAIRMAN. It is, because in these clinics they have a fairly narrow scope of what they can do, and usually there is not a doctor in the clinic. In some of them there is a doctor, in some of them there is not.

If there is a doctor there, obviously he can do anything he wants to do and feels capable of doing. But in most clinics they do a whole range of things, but there is just an awful lot of things they are not allowed to do simply because there is not a doctor present.

Mrs. PHILLIPS. The clinics that I am talking about, there are 12 doctors on staff all the time, where they do not go.

The CHAIRMAN. You are talking about a medical clinic?

Mrs. PHILLIPS. Medical clinics.

The CHAIRMAN. You are not talking about these public health clinics?

Mrs. PHILLIPS. Oh, no, I am talking about actual medical clinics, where there are 12 doctors on staff all the time.

The CHAIRMAN. Oh, I see. I am sorry. Well, we were not connecting on that, and I did not realize that is what you were talking about.

Of course, there are all kinds of clinics. All doctors have clinics. But I was thinking about what we call public health clinics.

Mr. Cole, how much money did you save when you raised your deductibility from $200 to $1,000?

Mr. COLE. Our premiums went from $60,000 to $90,000 over a 7-year period of time.

The CHAIRMAN. Went from $60,000 to $90,000?

Mr. COLE. Yes, sir.

The CHAIRMAN. Your premiums went up?

Mr. COLE. Thirty thousand dollars over 7 years.

The CHAIRMAN. Even though your deductibility went up, too?

Mr. COLE. Yes.

The CHAIRMAN. How could that be?

Mr. COLE. Well, utilization, and the money they spent on our group. We have young employees: childbirth, had some car accidents, that sort of thing. They show us the figures.

The CHAIRMAN. Well, when you first took it out it was cheaper, was it not?

Mr. COLE. Yes.

The CHAIRMAN. When you first went to $1,000 deductible you saved premiums on it, did you not?

Mr. COLE. Well, no, our last insurance policy about a year ago had a $500 deductible. And to maintain that would have been somewhere around $120,000 a year.

The CHAIRMAN. At $1,000, you went to $90,000?

Mr. COLE. Yes.

The CHAIRMAN. So the difference between a $500 and a $1,000 deductible saved you $30,000, at least the first year?

Mr. COLE. Yes. It was almost a dollar-for-dollar swap.

The CHAIRMAN. That is the best deal you ever made, was it not?

Mr. COLE. It was. We gave everybody a raise and their insurance, and said, "If you are wise, you will put this on your health care."

The CHAIRMAN. Mr. Cole, you also mentioned administrative expense, and I think you did, too, Bob. Obviously, one of the advantages, hopefully, that we are going to get out of this is a fairly massive cut in administrative expense. Of course, you anticipate those things, and then it never happens.

We have had one doctor testify in a hearing, that they very seldom see the same form. It just depends on who the insurer is.

I am going to tell you something else, and this is no disrespect to Blue Cross-Blue Shield, but I consider myself a fairly intelligent guy, and I cannot decipher my medical statements that come from Blue Cross-Blue Shield. I just look down at the bottom and say, "We paid this, and here is what you owe."

I must say they are much better now than they were a few years ago. A few years ago a Philadelphia lawyer could not interpret those things.

You said something, Mr. Cole, that I would like for you to elaborate on, if you could. You said that more is spent on administrative expenses for Medicare than is spent on services?

Mr. COLE. Yes.

The CHAIRMAN. Where did you get that?

Mr. COLE. I cannot quote the——

The CHAIRMAN. Not Rush Limbaugh, I hope.

Mr. COLE. No. No, sir, I did not hear it on Rush. I think from our home health agency. I do contract work for Washington Regional Home Health Service, their home health agency.

The CHAIRMAN. Incidentally, I am a great believer in home health care.

Mr. COLE. Well, I am, too. We do a lot of good work in home health.

The CHAIRMAN. Are you all involved in that?

Mr. COLE. Yes.

The CHAIRMAN. Well, I am on your side.

Mr. COLE. We see a big change from having seen the patient in the hospital, and by the time they go home, all of a sudden they are back in their home environment, they have access to their familiar surroundings, and they really blossom and start to do better. I think that is money well spent.

The CHAIRMAN. I must say, Mr. Cole, I believe that figure is grossly in error.

Mr. COLE. Well, I hope you are right.

The CHAIRMAN. I promise you it is.

Mr. COLE. But I wanted to bring it up.

The CHAIRMAN. Well, we spend about $140 billion a year on Medicare, and maybe more than that. It is somewhere in the $150 billion range, I think. While the administrative expense is probably excessive, my guess is that it would not be beyond 5 to 10 percent of that amount. But I will find out, and I will get back to you.

Mr. COLE. Well, I am in gross error, then.

The CHAIRMAN. I will contact you so we will both know.

Mr. COLE. Well, I would appreciate it, because I have got a bad feeling about that.

The CHAIRMAN. Now, Ms. Kelley, you have this credit union, and you do not carry insurance of any kind?

Ms. KELLEY. That is correct. I am the only employee. I do have a part-time person that works a couple of hours a day, but we do not provide anything.

The CHAIRMAN. Let me ask you this, and if this is proprietary information you do not have to answer it. But do the wages of the employees in your credit union exceed $12,000?

Ms. KELLEY. Yes.

The CHAIRMAN. Would it exceed $15,000?

Ms. KELLEY. Mine does at this time. If they were to hire another person, it might not necessarily, depending on their experience.

The CHAIRMAN. Well, do you think $15,000 might be just about an average salary of the people there?

Ms. KELLEY. Yes.

The CHAIRMAN. Are you familiar with the sliding scale that is proposed for small business people?

Ms. KELLEY. No, sir.

The CHAIRMAN. The maximum anybody would pay under the plan is 7.9 percent. The definition of small business—and this is another thing that is obviously going to be changed, and as a matter of fact, I am going to try to change it—is anybody with 75 or fewer employees. I know a lot of people with 100 and 150 employees who are just barely keeping their head above water, and they are considered small business.

Under the President's plan, if you have over 75 employees you are not small business, and therefore you must pay 7.9 percent. If you have fewer than 75 employees and the average wage in your plant or in your facility is $12,000 or less, you pay 3½ percent of the payroll. That's a very dramatic reduction of over 50 percent.

If the average wage were $15,000 in your facility, you would pay 5.3 percent. Then, if you get up to where the average wage in your facility is $24,000, you then pay the full 7.9 percent. It is a sliding scale.

I must tell you I do not quite understand that. There are a couple of things about it that perplex me, and in my opinion that is going to be changed, to try to accommodate small business, so that we actually do not cause people to shut their doors.

I am not promising you anything is even going to pass. I would be less than candid if I did not tell you that the enthusiasm for this legislation has been waning in the past few months. A lot of that is the Whitewater distraction and all that sort of thing, but that will ultimately go away and we will get back on track with both this and welfare reform, which is also very essential, in my opinion.

But, it does not make a lot of sense to say to somebody, "If you will keep your wages below $12,000, you will only have to pay a 3½ percent premium." That is not the way government ought to be encouraging people. We ought to be encouraging them to pay more, if they can, to their employees.

The other thing we say is, "If you go above 75 employees, even though you have been paying 3½ percent premium, if you have more than 75 employees you have to pay 7.9 percent" The incentive is to keep your employment below 75. Now, those two things make no sense to me.

Does anybody else have anything that you want to get off your chest before we dismiss this panel? Let me thank you again. Every one of you have spoken very intelligently and very sincerely, and I appreciate your taking the time to be with us this morning.

We are going to take a 5-minute break here, and our next panel can be getting seated. Our next panel consists of Sister Judith Marie, CEO, St. Edward Hospital in Ft. Smith; Dr. Charles Klepper, internist, from Harrison; Dr. Ben Hall, family practitioner from Lincoln, who I note in his testimony wonders why on earth he is here; Dr. Dan Johnson, Ft. Smith Rehabilitation Hospital in Ft. Smith.

[Recess.]

The CHAIRMAN. The next panel is seated. Sister, you are first on my list, so please proceed.

STATEMENT OF SISTER JUDITH MARIE KEITH, CEO, ST. EDWARD MERCY MEDICAL CENTER, FORT SMITH, AR

Sister JUDITH MARIE KEITH. Senator, I am honored to be a part of this hearing on health care reform.

My name, as you mentioned, is Sister Judith Marie Keith. I am president and CEO of St. Edward Mercy Medical Center in Ft. Smith, AR, which is comprised of a tertiary medical facility, three rural community hospitals, and a freestanding psychiatric hospital. We have two of those walk-in clinics that you referenced, and we have just recently opened a public health clinic down in Wicks, AR.

The CHAIRMAN. Also the hospital where my Number One son was born.

Sister JUDITH MARIE KEITH. That is right. Another development, as far as this integrated network, is that we have recently begun employing physicians. We have, I think, 9 physicians now employed in rural areas.

As far as the need for reform: You know, like I do, that today millions of working Americans and others cannot afford or otherwise obtain health care insurance, and are often excluded from the benefits of our Nation's health care system.

Paradoxically, nationally, health expenditures are escalating rapidly, seemingly without control, and are consuming increasing portions of the Nation's wealth. The health care delivery system is fragmented, and lacks economic discipline.

We have reached the point where one thing is certain: If Congress fails to act forcibly, comprehensively, and soon, things will only get worse. We no longer have the luxury of ignoring the problem and hoping that some day, somehow it is just simply going to go away.

Similarly, partial or incremental approaches are no longer an option. The underlying problems are systemic in character, and can only be addressed through systemic change. Let me spend a few minutes addressing what I see as essential components of health care reform.

Universal coverage: I am a very strong proponent of this. It has to be an integral part of health reform for both moral and pragmatic reasons. We should no longer tolerate being the only western industrialized Nation that has millions of people without health

care coverage. I think the latest figure I saw was around 37 to 38 million of our, what, 280 million population.

The coverage must also include portability, such that Americans with preexisting medical conditions can change employment without fear of losing their health insurance. Research has shown repeatedly that the 37 million under- or uninsured are more likely to forego or postpone care than their insured counterparts.

The pragmatic reasons for universal coverage are equally compelling. Anything less than universal coverage creates a vicious circle whereby the uninsured are more likely to receive care in costly settings and for conditions that have grown more severe with time. The resulting high cost of this care is then shifted to employers; who, in turn, find insurance coverage for their workers increasingly unaffordable. We must break this vicious circle if there is ever to be any hope of controlling health expenditures in this Nation.

Efficiency and quality: Most viable health reform plans rely heavily on market forces to control health care costs and to improve quality. They accomplish this by shifting much of the financial risk from the purchasers of this care to those who are providing the care, hospitals and doctors, who then compete with one another on price and quality for market share. In certain areas of these United States, economic forces are already forcing local health care systems to reorganize themselves along these lines.

While it is hoped that these developments will result in lower costs and higher quality of care, it is important to recognize that they represent a profound shift from existing practices.

During the past 50 years health providers have been, to a high degree, shielded from financial risk, and have too often treated their patients with little concern for the economic consequences. This has certainly helped preserve a very strong professional, patient-first ethic in American medicine.

While some are occasionally overtreated, few insured patients are ever undertreated, in my opinion. I believe that shielding the clinician and patient from the economic consequences of their actions has led to a level of inefficiency and high cost that is no longer economically or politically sustainable.

The benefit package: I encourage the crafting of a basic insurance package that adequately provides for the health needs of all Americans. With this available at an affordable cost, and portable from employer to employer, coverage of the working poor and the uninsured should be the responsibility of government. I also urge you to incorporate Medicare and Medicaid funds into the health alliances, along with most other forms of financing, otherwise the vicious circle will simply continue.

Now, allow me to share with you a few of my concerns which I believe health reform must strengthen.

First of all, there must be sharper focus on reform of the health delivery system. As it now stands, most proposals say very little about how the health delivery system can and should be reoriented to achieve both lower costs and clinically effective health care. We simply have to move from the curative model of health care to more of a preventive model of health care. To go the curative

route, it has been estimated, costs about three times as much as trying to prevent illnesses.

Incentives also must be available to encourage primary and preventive care of this nature, as well as unnecessary care, better coordinated care, and less costly settings. I also have to say, as far as tort reform, I am very much a proponent of mandated arbitration.

Abortion: I feel strongly on both moral and political grounds that the inclusion of abortion in any guaranteed benefit package provided under health reform, though legal, is strongly opposed by millions of employers and taxpayers. The government should not compel them to pay for abortions. This, then, leads to my support for the inclusion of a conscience clause provision for individuals, for institutions, and for employers in health reform legislation.

Finally, I conclude my testimony with a focus on values. Values are the beacons which guide us, especially in stormy times when our sense of direction can become distorted. Values also provide us with the criteria by which we can measure our progress. However impressive governmental programs, universal coverage, fee schedules, and institutions may be, successful health care reform will come down to people caring for people. When we are sick and in need, it is the small events of our lives that make the difference.

The values which direct our decisions and behaviors, the values that will create the balance between the terrible focus on cost versus caring, these are the issues by which future generations of Americans, their families, and communities will judge the success of what we are beginning in health care reform. They are the issues we must keep before us throughout this reform effort.

The CHAIRMAN. Sister, as usual, you have made a very thoughtful statement, and I thank you very much for it.

Dr. Klepper?

STATEMENT OF DR. CHARLES KLEPPER, INTERNIST, HARRISON, AR

Dr. KLEPPER. Senator Bumpers, it is indeed an honor to be asked to participate in your Committee's hearing on health care reform. After many years of debate, it would appear that our Nation is ready for comprehensive changes. There are now at least 6 major health care proposals before Congress, to my knowledge, and the proposals are certain to lead to one of the most important changes in our Nation's history.

As no one proposition has definite assurance of passage at this point, I have chosen to address my remarks on more general terms of what the objectives that I and my colleagues feel are essential in the final legislation.

One: All Americans should have access to an affordable health care plan. Physicians everywhere agree that no one should be denied health care. It would appear that most Americans prefer to pay for their health care through the purchase of insurance whenever possible.

The President's plan and a majority of the other plans have proposed that no one should go without health care coverage. It is hoped, therefore, that Congress will be able to find a way to provide affordable insurance to every American. My concerns, as a

rural practicing physician in Arkansas, primarily reflect how this coverage will be financed.

While an employer mandate is the most feasible way to achieve universal coverage, many small businesses in my area will have considerable difficulty in meeting insurance premiums for their employees unless subsidies are provided as per the Clinton proposal.

It is the feeling of my colleagues, as well as physicians from Canada and other countries with whom I have discussed health care over the past several years, that increased taxes are also inevitable as part of our health care reform financing.

As it is common knowledge that, together, tobacco and alcohol are associated with most of the major chronic illnesses afflicting our population, it seems only fair, from a physician's standpoint, that those individuals who choose to undertake or continue these negative habits be expected to pay a higher percentage of the financing of the increased illness resulting from them.

Two: Individuals should have a choice of health plans, carriers should be required to offer a standard benefits package, and be prohibited from engaging in discriminatory practices. One of the major concerns of my colleagues is that during the two preceding administrations health care coverage has been denied to those individuals with preexisting conditions, or has been priced beyond their reach by rate variations based on health status or the risk of an employee group. It is essential that this practice be eliminated in order to provide fair coverage for everyone.

Three: Health reform should attempt to relieve unnecessary regulatory requirements which were enacted in the previous two administrations. Physicians have been overwhelmed in the past 12 years by regulations involving medical care.

While these were initiated by well-intentioned proposals, their net effect has been to restrict access to the health care system by those patients who need it most. Government issued comparative performance reports on utilization of services were planned to be educational, but when actually implemented, they negatively targeted physicians with large Medicare caseloads.

Rather than face repeated demands to copy records, supply additional documents, et cetera, on patients with multiple coexisting diseases, many physicians in our area have been forced to limit their numbers of Medicare and Medicaid patients. CLIA '88, which was passed after controversial hearings on complex testing such as PAP screens, has had the effect of causing most of the physicians in our community to stop doing simple, automated laboratory testing in their offices because of the regulatory costs and administrative burdens of doing so, again thereby restricting access. Until recently, peer review organizations (PROs) were only able to issue punitive sanctions for care that did not meet a predesignated laundry list of practice patterns.

Senator it is our sincere belief that the majority of physicians are honestly trying to provide care in as cost effective and prudent a manner as possible. It is hoped that as part of health care reform, regulations in the future will be more educational and less confrontational.

An example would be the current scope of work by PROs to provide educational information on practice patterns throughout our state, with the hopes of finding the most efficient and successful treatment modalities for various disease groups. Physicians would welcome this, and this would be more cost effective than previous attempts to punish physicians for outcomes that are many times beyond their control.

Four: Medical liability reform is essential if costs are to be controlled. Never before in our country's history have physicians closed their practices early or changed their careers from medicine in such numbers as is currently the case. Nursing is also in a continued state of flux, with average career length of registered nurses reportedly only 2 years.

While the estimated cost of defensive medicine is reportedly 20 percent of the total health care dollar, when the additional cost of retraining individuals to fill the ranks of the profession are included, as well as the administrative cost of defense and documentation, the true cost is much higher.

Physicians are perpetually caught between unlimited patient expectations and limited resources. Unless some relief on non-economic damages is included in health care reform, the primary care physician shortage can only be expected to worsen.

Five: Reform should not be financed by unrealistic cuts in Medicare spending. The elderly are the fastest growing segment of our population, and are expected to remain so for the next 40 years. If health care reform relies excessively on cuts in Medicare, unless an alternative health care plan is provided, this will result in reductions in the level of care provided to these patients, which will be unacceptable to both the patients and their families.

Six: Negotiated spending targets should be adopted instead of rigid, formula-driven ceilings. Rigid limits on total spending will quickly lead to rationing of care, as was demonstrated in Ontario last month with the Canadian system.

They will also not allow for unexpected changes in disease modalities, as has been experienced worldwide with AIDS this past decade. A better way would be to allow spending targets, which would allow flexibility, and to give everyone involved in health care a say in what could be done next if the target could not be met.

Seven: Physicians should be included in a presidentially appointed health care board, to provide their medical expertise in decisions that directly affect patient care. Physicians should be allowed to serve on the proposed health care alliances for the same reason.

Eight: Physicians should be given anti-trust protection to negotiate with health plans and form their own ventures, to compete with those organized by insurers and hospitals. They must be able to negotiate on payment levels, controls over their practices, and issues affecting the health care of their patients. If cost effective, they should be allowed to form their own competing ventures.

In conclusion, physicians appreciate the need for health reform. The current system has proven to be too expensive, and in too many instances, too difficult for the average American to obtain. Physicians welcome the opportunity to participate in helping to

formulate a more cost-effective and all-inclusive health care package.

Too often in the recent past, physicians, insurers, legislators, hospitals, and businesses have been at odds over health care issues. It is to everyone's advantage if we can work together to improve total health care by reducing costs, and improving rather than restricting access to the system.

I thank you for the opportunity to express my views.

The CHAIRMAN. Thank you, Dr. Klepper. That is an excellent statement. You raise a couple of points we will come back to in a minute that nobody has raised before.

Dr. Hall?

STATEMENT OF DR. BEN HALL, FAMILY PRACTITIONER, LINCOLN, AR

Dr. HALL. Well, I think everything I had to say has been said, and more eloquently than I could say it. As I was getting dressed this morning to come out here, I was wondering if I was going to make any difference, or if what we are doing was going to make any difference. And I told my daughter I was going to talk with Senator Bumpers, and her statement was, "Cool, who is he?"

The CHAIRMAN. She is in good company.

Dr. HALL. I am a rural practice doctor in a town of about 1,500, and have been for about 10 years. For 8 years I practiced solo. Over the last 8 years of my practice, the administrative demands have increased by about eight to tenfold, taking a whole lot of time away from my patients. I also serve a patient population that keeps me quite busy.

The CHAIRMAN. How many doctors are there in Lincoln, incidentally, Dr. Hall?

Dr. HALL. Well, for the last 2 years there has been two, because my dad retired at age 67 and came out to help me.

The CHAIRMAN. Just the two of you?

Dr. HALL. Yes.

The CHAIRMAN. Well, I grew up in a town about like Lincoln. As a matter of fact, we used to play them in football. We are a town of ones: one bank, one hardware store, one doctor, one lawyer. You are being addressed right now by the entire South Franklin County Bar Association.

[Laughter.]

The CHAIRMAN. So I understand. Go ahead.

Dr. HALL. I think that, like I said, I do not have much to say that has not already been said. I would like to say that I think that you were not talking about my clinic when you were talking about capabilities of rural clinics, because we can do about 90 percent of everything that needs to be done out there, and basically, what we cannot do should be done in a hospital.

As a family physician, I do not see the problems that our Nation is facing as an organ problem or an organ system problem, but as an organism problem. I see our Nation as an organism, and I think that health care is just one organ system that is not running right. I think that the whole organism needs to be fixed.

We ought to start instructing our kids in grade school about the diseases and the illnesses that are going to incapacitate them, and when they are likely to be incapacitated by them.

I think that we ought to have a design in our school system so that the kids who have certain genoms will know what kind of preventive care they are going to need to have during their lives. They are going to know that in the first 45 years of their lives, alcohol, tobacco, traffic accidents and things like that are going to be the most likely thing to make them disabled. I hope that is going to make a big difference in the need for health care and the utilization of health care.

Just to revamp what everybody has said, I think that the major thing is to try and make health care affordable and available to the majority of Americans, and I think that we need to promote responsibility in limiting unnecessary use of medical care, which will prevent dangerous rationing by third parties. I think it will create effective and more satisfying medical care by allowing freedom of choice of doctors.

Freedom of choice is one of the keys to our medical system, because I believe that the science of medicine is probably not nearly as important as the art of medicine. I do not think that you can practice your art with somebody who does not believe you are an artist.

I think that in order for people to achieve health, they need to believe that the person who is taking care of them cares for them. The doctor needs to be able to care for people that he actually cares for. There should be a two-way street, so that the care can be given and received. Because, when you take out the 20 or 30 or maybe even 40 percent that is science, you are left with a whole lot of art.

I think we ought to limit the administrative costs of medicine. Administrative costs of medicine, as I said earlier, are kind of drowning me, and there has been probably not one day that has gone by in the last year that I have thought maybe I ought to sell my practice to Washington Regional, or maybe I ought to sell my practice to some other group, then I could just work for somebody other than my patients, which is not going to be good for my patients.

We also need to prohibit excessive doctor fees. I think we need to prohibit excessive lawyer fees. We ought to have tort reform. We need to define what effective treatment is. The NIH needs to go to work and decide what we have proven is going to be effective, is going to benefit our Nation, is going to put people back to work or keep them from losing time at work, and offer that kind of medical care. I think that is going to save our Nation money. But I do not think it is going to save our Nation money to do expensive, unproven procedures on people who may not benefit from it.

We need to stop defensive medical spending, but should reward carefully researched individual care that is effective and affordable. I think cognitive function and communication needs to be as important as procedures done on people.

We need to support our medical students, and try to keep them from forming large debts, in excess of $100,000 before they start their practice, because that just perpetuates the medical fees.

There needs to be incentives provided to ensure that there is availability of medical care in small areas or urban areas where people do not want to go to practice medicine.

I have a whole lot of problems recruiting physicians. I have been trying for 2 years, ever since my dad went into practice, to find somebody to come in to practice with me and help me. I run an evening clinic until about 10 p.m. every Tuesday night, but I cannot do it every day. I would like somebody there to help me; otherwise, my patients have to drive 40–, 45 minutes to Washington Regional Hospital, and it costs them a whole lot of money, and the people there do not really know what their health problems are or what they need. I cannot get somebody out there because I cannot compete with hospitals that are paying $125,000 to put somebody someplace. I cannot guarantee that to people.

There should be realistic reimbursement for home care that replaces hospital or nursing home care. I agree with you about home health, but the reimbursement for a physician to go out and see somebody in their home is about 20 percent of the reimbursement for a nurse to go out and see somebody in their home.

The nurse, on the other hand, has to deal with all the medical problems of that patient, and call the doctor, and the doctor has to make medical decisions based on a patient that he is hearing about over the phone, and take all the liability for that, and does not get reimbursed for it. There is really no incentive to care for people in the home.

If I leave my office, where I see 20 or 30 patients a day, to go out to somebody's home, which may take me 45 minutes, I could have seen 4 to 5 patients in that period of time. Plus, I would have had the equipment that I needed. There is just no incentive for me to do that, and there is no incentive for me to care for people in that manner. Not that I do not; there are four or five home health agencies that are right now bludgeoning me with calls every day, which takes up probably 45 minutes to an hour of my time.

In summary, I would like to say that health is not merely the absence of disease or infirmity, but it is a state of complete physical, emotional, spiritual, and social well-being. I think that we need to fix a whole lot of things besides health care before people are going to get healthy.

My feeling is, that those responsible for health care are the people that get healthy. If it is an insurance company responsible for your health care, they are going to get healthy. If it is a lawyer responsible for your health care, he is going to get healthy. If it is the patient responsible for their health care, they are more than likely to benefit.

The CHAIRMAN. Thank you very much, Dr. Hall. I read all of your testimony on the way up here this morning. You obviously put a lot of thought into it, and I appreciate that very much.

Dr. Johnson?

[The prepared statement of Dr. Hall follows:]

PREPARED STATEMENT OF DR. BEN HALL

Dear Senator Bumpers, I am a country doctor, and I must admit that I am a little befuddled as to why you would be interested in my ideas about health reform. Getting in front of a group usually makes my palms sweat, my voice crack and my

mind whirl with thoughts of running, but if I can be of help to my country or my patients, I'll try and give it my best shot. What I know is rural medicine in Arkansas. I've practiced solo in a town of approximately 1,500 population for 8 of the last 10 years. For the last 2 my father, who is an internist, has been helping me out. I do a full range of family practice, except Obstetrics, because the nearest hospital is over a half hour drive, and major surgery, because when I did this it barely paid the malpractice insurance raise for surgery and took too much time at the hospital in the middle of the day.

Since I have been in practice, the time I spend administrating my clinic has risen about eight to 10 fold. The amount of government rules and regulations has become oppressive. Because I practice in a small poor rural community, I don't have the income to hire highly trained personnel in my front office and if these people exist in my community, I can't compete for them against the large multi-specialty groups in Fayetteville and Springdale. Without these personnel much of the paperwork is left up to me and robs time from patient care.

It is also very difficult to recruit physician help since I can't guarantee them the grand salaries large groups and hospitals can.

Good comprehensive medical care is an integral part of rural America and it's from rural America that the U.S. gets an infusion of morality. I don't think we can, as a nation, afford to continue to ignore rural medicine. I will jot down a few of the things I feel are needed in rural medicine.

We Need Relief From Paperwork, Red Tape, and Government Regulations

1. Have medical equipment companies insure continuing quality control and quality assurances with their equipment and reagents. And do away with CLIA. I'm confident the free enterprise system will come up with foolproof ways to meet the regulations if it means dollars.

    a. Patients might as well go into the hospital for their care if they have to go there for their lab tests.

    b. The volume in a rural office is often too small to run controls which cost more than the reimbursement for a single test.

    c. Qualified personnel are hard to come by in a rural community.

2. Create a single global insurance form that must be used by all carriers.

3. Create an electronic insurance clearing house that must cross file secondary insurance. This house or houses should be the responsibility of the insurance companies. Delays in reimbursement should come with interest charges to the insurance companies equal to the highest prevalent bank card interest.

4. Create a medical records data bank.

    a. This would need privacy codes and would need to be accessed by the patient's doctor only.

We Need Help in the Trenches, Recruits, Finances, and Equipment

1. I need to know there is someone to care for my patients when I go for educational meetings and vacation.

2. Someone to run late night clinic part of the time so patients don't have to drive to the hospital after hours.

3. In order to recruit professional help there needs to be long term financial incentive to entice doctors to go into, and stay in practice in a rural community.

    a. In order to have the population base there may need to be a central well equipped office for several physicians and physician extenders to rotate through with outlying smaller offices used primarily for follow up appointments and minor illnesses.

    b. There needs to be realistic reimbursement for home treatment, and acute and chronic care.

    c. Incentives for continued medical education.

4. In order to practice up to date medicine and compete with large urban centers for the few who can afford medicine there needs to be up to date equipment.

I think university and government support of rural health should be as good as university and government support of the rural farmer. Teach us! Lead us! Help us with soil tests. Develop new and reliable machines in our lab and x-ray, help us to become better doctors.

Finally, I hope you will involve as many practicing doctors as you do university doctors. I must add however, that doctors, at least rural doctors, are understaffed and very busy caring for the sick. They will probably not stop to think and talk about planning. They are doers. You might have to go to them.

Next, I will step out of my element and toy with a few ideas my Dad and I have battered around about more global health care reform. I must preface this by saying that what our entire health care system needs is a massive infusion of morality from the doctors and nurses through the politicians, insurance companies, and lawyers, down to the patients and their families. Morality has never been successfully legislated, and I have reservations as to whether medical reform will be either. I think it will require either global reduction of health care quality or significant rationing. I suspect this is why our Founding Fathers left it as a happiness we can pursue. That being said, I will jot down a few of our ideas.

FOSTER SACRIFICIAL SERVICE

This Is Service Rendered in the Spirit of Giving

Set up community centers administered by community volunteers for the care of the needs of the truly indigent. These can be monitored by senior congressional aids as a voluntary service.

a. Drug companies can give medications and get a tax advantage.

b. Community physicians and pharmacists can donate time and expertise caring for the indigent's medical needs with a tax advantage.

c. The needy could receive many other benefits through something like this, food, clothing, shelter, jobs, etc.

d. A data base of needy versus abusers could be set up.

Health Care Reform Must Not Limit Medical Research and Development

1. Lives would be lost.
2. Suffering would be increased.
3. The American health care industry would lose its world leadership with loss of jobs, etc.
4. Care of the disabled would become more expensive.
5. New discovery and new treatments offer hope. The government should support potentially helpful research and development.

Health Care Reform Must Not Destroy the Doctor/Patient Relationship

1. This is the core of the art of medicine.
2. The art of medicine is important in all medical treatment.
3. More than 50 percent of medical illness can be treated only by the art of medicine.
4. Doctor/patient compatibility must not be fostered. Free choice of doctor and free choice of patient is important.

Health Care Reform Must Not Allow Insurance Companies, Administrators, Lawyer, Politicians and Advertising Agencies to Derive Most Benefit From Health Care Delivery Than the Patient and the Doctor

1. This will price medical care out of the reach of all Americans.
2. This will destroy incentive to assume responsibility for one's health.
3. It will destroy the incentive to become a doctor.
4. It will lead to false hopes and expectations of medical care.
5. It will produce endless snowballing of health care costs.

Health Care Reform Must Make Every American More Responsible and More Effective in Preventing and Treating All Conditions That May Cause Illness or Infirmity Throughout Their Life

1. Leading cause of death and disability before age 40 (the most productive years of life are:

Accidents (MVA)
Suicide
Homicide
Drug suicide/homicide
Drug alcohol and tobacco related illness.

One must be responsible for his own health to prevent or treat these illnesses.

2. Health education in public schools, homes and churches must drastically be restructured.

3. National, state and local government, schools, churches and the work place must work to make every American responsible, motivated, and skilled and disciplined in health care.

Health Care Reform Must Make Health Care Affordable and Available to the Majority of Americans

1. This promotes responsibility in limiting unnecessary use of medical care and tends to prevent dangerous rationing by third parties.
2. It would create effective and more satisfying medical care by allowing freedom of choice.
3. Care can be made affordable by:
   a. Limiting administrative costs.
   b. Prohibiting excessive MD and lawyers fees.
   c. Tort reform.
   d. Defining effective treatment.
   e. Stop defensive medical spending.
   f. Reward carefully researched individual care that is effective and affordable.
   g. Cognitive function and communication must be as important or more important than procedures.
   h. Support medical students to prevent large debts.
   i. Incentives must be provided to assure availability in some areas.
   j. Realistic reimbursement for home care that replaces hospital or nursing home care must be available.

Health Care Reform Must Assist Underprivileged Americans in Obtaining All Preventive and Therapeutic Medical Care that is Proven Effective

1. National Institute of Health or similar organizations must work 24 hours a day to define effective care in virtually all diseases.
2. Centers of excellence for unusual diseases and very expensive diseases must be established.
3. Doctor shopping cannot be reimbursed by society.

In closing I might say that health is not merely the absence of disease or infirmity but is a state of complete physical, emotional, spiritual and social well being.

More specific goals of health care are to preserve productive life, to prevent disability, to relieve unusual suffering.

It should not be the goal of health care to prolong dying. Immediate rationing of medical care is necessary in expenditures in the last 6 months of life and expenditures that are made for ineffective or dangerous medical care.

STATEMENT OF DR. DAN JOHNSON, FORT SMITH REHABILITATION HOSPITAL, FORT SMITH, AR

Dr. JOHNSON. Good morning. I would like to just make a brief statement.

I represent a profession known as neuropsychology, a profession which, during the past 5 years, has offered much to the diagnosis and treatment of those persons afflicted with neurological disorders; for example, traumatic brain injury, strokes, Alzheimer's dementia, spinal cord injuries, to name a few.

At present, most neuropsychologists work in rehabilitation hospitals to assist patients afflicted with various neurologic and/or physical medicine problems. The status of my profession is badly in need of enhancement to be more effective than it is already.

For example, insurance companies and Medicare do not recognize the importance, necessity, or role of neuropsychology. Rehabilitation hospitals add staff neuropsychologists as a necessity to complete the treatment of the whole person, but Medicare and the insurance industry does not appreciate the extreme importance there is to understanding such problems as the remediation of memory, problem-solving, or working with the emotional problems which often accompany neurological problems.

In this process, to be truly effective, the future of neuropsychological rehabilitation needs greater support. But any future legislation must focus on how important long-term care is required for a neuropsychological rehabilitation.

In addition, greater support must be given to increased rehabilitation technology. Neuropsychology has a vested interest for the development and evaluation of assistive devices for persons with severe disabilities, human performance evaluations, rehabilitation telerobotics, integrated work stations, and implantable electrodes for chronic recording of neural signals.

Finally, clinical services can be improved with neuropsychological research. The President has already expressed an interest in greater funding to assist with research for the understanding and treatment of neuropsychological problems. I applaud this interest.

My comments are brief, but I have a great deal of conviction and a great deal of depth involved in the development of these statements. Thank you for the opportunity to express my thoughts and feelings about health care reform.

The CHAIRMAN. Thank you, Dr. Johnson.

The CHAIRMAN. Dr. Hall, how many times do you look and say, "Oh, my God, is she here again?"

Dr. HALL. Gosh, I do not know.

The CHAIRMAN. Does that ever happen?

Dr. HALL. Oh, yes.

The CHAIRMAN. Does that ever happen to you?

Dr. HALL. Sure. Almost as many times as I say, "Oh, my gosh, I am here again."

[Laughter.]

The CHAIRMAN. Sometimes she needs to maybe go see Dr. Johnson, huh? Well, you and Dr. Johnson can get acquainted, and maybe you can start referring her to him.

Dr. JOHNSON. I was pleased with some of your comments——

The CHAIRMAN. We always just had one of everything in Charleston, and the doctor in particular was a good friend of mine and I got to know him, and we used to share experiences. I was the only lawyer in town; he was the only doctor. And he told me one time an interesting story about when he was doing what they called a preceptorship. You go out and practice with some doctor for——

Do they still do that?

Dr. HALL. You bet.

The CHAIRMAN. Similar to the AHEC program, but different.

He went out in the country in North Franklin County one night, and the doctor he was doing his preceptorship with was a very devoutly religious person. They had gone out to make a house call on this elderly woman, and this doctor starts trying to save her soul. Finally this old woman said, "Son, when I send for a preacher, I want a preacher; and when I send for a doctor, I want a doctor. But when I send for a doctor, I do not want a doctor-preacher."

Yet, as you and Dr. Johnson both said, there is something to the idea of the whole person. A lot of those people, when you say, "My goodness, is she here again?" the truth of the matter is she does have need of counseling, oftentimes, or some kind of care. But I do not know, I think most doctors probably go ahead and go through the routine of treating her, is that a fair statement? I am referring to a particular kind of patient who just can never quite get enough medicating.

Dr. HALL. You mean, do we see the patient and try to deal with their needs?

The CHAIRMAN. Yes.

Dr. HALL. Yes, we see the patient, try to deal with both what they need and what they say they need.

The CHAIRMAN. Do you refer patients for counseling quite often?

Dr. HALL. I would not say quite often. But for the counseling that I do not feel equipped to do in my office, I make referrals. I probably do 90 percent of the counseling in my office, but there is 10 percent of the cases that I think are too critical, and they need a psychologist or a psychiatrist.

The CHAIRMAN. Dr. Hall and Dr. Klepper, and Sister, you certainly have an interest in this—the AMA, according to big stories in the New York Times and the Washington Post about a week ago, are apparently coming out with their fighting clothes on about increased responsibilities for nurse practitioners. How do you feel about that, Dr. Hall?

Dr. HALL. I think nurse practitioners or physician's assistants are probably the way to go in small areas like mine. If you had two or three doctors in Lincoln, and you had a rotation through outlying clinics manned predominantly by nurse practitioners, maybe three or four outlying clinics that really did not have the capabilities of the major clinic in Lincoln could do minor illnesses and follow-up exams and things like that, with the doctor going through there every once in awhile to enhance the populace's feeling of complete care. I think that that would benefit everybody. Then you can shuttle, for things that needs to be done like blood drawing, X-rays, annual physical examinations, and setting fractures, and that sort of stuff, to the central office.

The CHAIRMAN. Dr. Klepper?

Dr. KLEPPER. Well, Tip O'Neill said all politics are local. I think each medical community would have their own set of problems.

But I think nurse practitioners could serve a very important role, particularly in the care of the elderly, as many seniors have problems getting into a doctor's office or a clinic situation. They can also serve in a number of other situations: prenatal counseling, to a certain degree. In many other areas they may be the patient's only access to medical care.

The CHAIRMAN. Sister, what are your thoughts on that?

Sister JUDITH MARIE KEITH. First of all, I believe in the whole concept of physician extenders. I do find that the attitude of our physicians toward physician extenders is positive. Not only in the rural communities, but also in specialty areas, like obstetrics, there is a lot that a non-obstetrician can do.

In light of the significant shortage of primary care physicians that we have nationally, I also think that physician extenders may well be part of the solution.

The CHAIRMAN. There is a statistic, admittedly from the National Nurse Practitioner's Organization, that says their diagnosis and their prescribed treatment is the same as a majority of physicians in almost 90 percent of the cases. Now, if they have that kind of a track record, they are being under-utilized, in my opinion.

As you know, I grew up in a rural area where the county health nurse was essentially our only source of health care. Incidentally, Betty is a very strong believer—and Sister, you covered this in your testimony—in preventive health care. She has spent her

entire public career, since I have been in public office, and has spent all of her prestige and time in childhood immunization.

And that is paying off very handsomely right now. I think we maybe had 250 cases of measles in this country last year. Three years ago we had 27,000 cases, and 32 deaths. So when you talk about preventive medicine, immunization, in my opinion, is "number one."

In any event, in rural areas it seems to me that nurse practitioners can serve a much greater purpose than they can in metropolitan areas, for example.

Sister JUDITH MARIE KEITH. I might just mention that in Wicks, AR, that is a community probably of 700——

The CHAIRMAN. I had a wreck in Wicks, AR, one time.

Sister JUDITH MARIE KEITH. Did you? You are through that town before you know it is a town. But the fact is, those people did not have a point of access. They were very poor. Many of them could not speak English.

We put a nurse practitioner down there in what you are calling a public health clinic, but we call it a rural health clinic. And the fact is, I have had neurologists and other physicians say that her diagnosis is as good as, and many times exceeds some that she has received from physicians. So I think that supports your statement that there are areas where a nurse practitioner can function very, very effectively under the umbrella of a physician.

The CHAIRMAN. It seems to me that if we could expand that program to the point—I mentioned there are 34 access public clinics in the state and some of them do have doctors, but the majority do not.

But where you cannot have a doctor, if you had an experienced nurse practitioner, it seems to me that that would be a very dramatic improvement in rural health care delivery, and would also provide a dramatic decrease in health care costs for the country.

I am not just talking about their cost, but I think one of the big controversies is that some doctors maybe feel threatened by nurse practitioners. One of the biggest controversies is whether or not, on a limited basis, nurse practitioners would be allowed to order prescriptions.

Sister JUDITH MARIE KEITH. It might make it less painful for the medical community if they actually engaged or employed the nurse practitioners.

The CHAIRMAN. Changing gears, Sister, you said something that is very unique for a hospital administrator or CEO to be saying, and that is: Providers have too long been shielded from the economic consequences of their actions.

In other words, no matter how much medicine a doctor prescribed, and no matter how many days you stayed in the hospital, you did not care because somebody was picking up the tab. Is that what you are saying?

Sister JUDITH MARIE KEITH. That is exactly what I am saying. I will have to say that when I was in graduate school I never heard the word "productivity." I never heard it. We have 1,500 employees, and if you do not know how to manage your folks, you cannot manage your business. I remember one time being roasted with the CEO at the other major hospital in our community, and the theme

song was, "Anything You Can Do, I Can Do—" I mean, duplication was rewarded.

We have been brought up, in health care, from the perspective that there is really no bottom to the sack. We talk about hitting people in the heart, or with their pocketbooks. If we can all be financially driven in the same direction, then the doctors will be nudging hospitals, and hospitals will be nudging physicians to look at costs while maintaining the quality. So, I stand by my statement.

The CHAIRMAN. On the issue of preventive health care, which I have always advocated—and I am not a Johnny One-Note—but I often wonder: Am I really as right as I think I am about preventive health care? Mammography, immunizations, blood pressure, all those things.

Hubert Humphrey used to make an endless speech on the floor of the Senate about, "We talk about national health insurance. We ought to call it national sick insurance, because it is not worth anything unless you get sick." This was back in the late 1970s, and he used as an illustration when the Ford Motor Company decided to self-insure about half of their employees.

One of the things Ford did was to give everybody over the age of 40 a physical every year, and those under 40 every other year.

Ford talks about all the preventive medicine they practiced. They had gymnasiums in all their plants where people could get physical exercise and so on. They found that they cut their health care costs by roughly 25 percent from what they had been paying.

I have always been impressed by Hubert's speech, and I think there is a lot of merit in it. And, let me once again say that people owe Betty a lot more than they will ever owe me, because she has really been out in the trenches immunizing children. She is on the road all the time actually doing something.

But when you think of the millions of man and woman hours of work that have been saved by children who did not have measles, who did not have mumps and who did not have all those other preventable childhood diseases, it is remarkable.

Right now it is incredible that the immunization levels of this country, like on DPT, are something like 82 percent. That is almost enough to say that you are home. Of course, it is important that we not let our guard down, that we keep it going.

Sister JUDITH MARIE KEITH. Senator, can I just comment on that? You have mentioned the trillion dollars that we are going to be expending for health care. And I will bet, if we put a pencil to it, that in America our financing that trillion dollars, probably 98 percent of it is going to cure the problem after it has happened.

There has really not been governmental funds to do what Dr. Hall was talking about, by educating people; about giving incentives to providers and individuals to maintain their health, so that they are not smoking and drinking and being obese. We really have to move from this curative model of health care to more of a preventive model, and we need to put the bucks there to get everybody's attention.

The CHAIRMAN. You know, just to give a little anecdote. I have a very good friend, a woman who has emphysema, dragging one of those things around when she can get out of bed. She's on an

oxygen tank 24 hours a day and so on. Recently I asked her, I said, "How much time do you spend thinking about a lifetime of smoking?"

And she said, "I never get it off my mind. I cannot believe I did that to myself." And she has two daughters, both of whom smoke, and have smoked all of their life. Yet, that is not a sufficient enough issue.

She said something about the tax on cigarettes. She said, "I hope you do not put a 75 cent tax on cigarettes, I hope you make it a dollar and a half."

Sister JUDITH MARIE KEITH. In Canada I think it is five, is it not?

The CHAIRMAN. When you look at the statistics on how much we spend on health care in this country, at some point, you know, everybody is going to die. And geriatric care in this country is very expensive. The older they get, as you know, Sister, the more it costs in their declining years. Yet, to gratuitously assume the kind of medical burdens we do for smoking is just unbelievable.

Sister, the President strongly supports a conscience clause on abortion, which you mentioned.

Sister JUDITH MARIE KEITH. Thank you. Good.

The CHAIRMAN. I think it would be unconscionable, I must tell you, if abortion is in this bill, I will be one of the most shocked persons in the United States Congress. It might possibly make it through the Senate, but it would never, in my opinion, make it through the House. But certainly, if it did, there would be a conscience clause.

Dr. HALL. Senator Bumpers?

The CHAIRMAN. Yes.

Dr. HALL. In response to your preventive care statement, I think that I would have to say that—going back to what I said about having the NIH define what is valuable to the Nation as a whole. Because I think physicians can construe almost any kind of test to do to prove that you are not going to have this or you are not going to have that, or you do not have this, that is not necessarily a proven test. I think it can get out of hand. So, I think there has to be a definition as to what preventive care we can afford and what we cannot.

The CHAIRMAN. How much do you pay for medical malpractice?

Dr. HALL. Well, am I supposed to say that?

The CHAIRMAN. You do not have to. Listen, anytime I ask a question that you consider to be proprietary information——

Most doctors are happy to tell you what they are paying for medical malpractice, because they hate it so much.

Dr. HALL. I think it is $6,000 or $7,000, somewhere around there.

The CHAIRMAN. Dr. Klepper?

Dr. KLEPPER. In that neighborhood.

The CHAIRMAN. Has it come down any in recent years?

Dr. KLEPPER. No, sir.

The CHAIRMAN. It has not?

Dr. KLEPPER. No, sir.

The CHAIRMAN. Did you know Arkansas has one of the lowest medical malpractice premium rates in the Nation? Maybe the lowest.

Dr. KLEPPER. Yes.

Dr. HALL. Actually, we have gotten a little rebate every once in a while.

The CHAIRMAN. Do you?

Dr. HALL. They send us a little bit of money back because we do not get sued so much. But it does not keep us from being scared to death that we are going to be sued on every patient that walks in the door.

The CHAIRMAN. What is your premium, Sister?

Sister JUDITH MARIE KEITH. I do not practice medicine.

The CHAIRMAN. No, but your hospital?

Sister JUDITH MARIE KEITH. If I were an obstetrician, my premium would probably be $30,000 or $40,000; and if I were a neurosurgeon, it would probably be $60,000 or $80,000 a year. I saw the bill for our insurance the other day, and it was, like, $400,000—and we are a self-funded pool, but that is what we pay.

The CHAIRMAN. Do you agree with the statement, all of you, that I made a moment ago that the cost of the premium was probably not nearly as great as the cost of defensive medicine that people practice to keep from being sued. Is that a fair statement?

Dr. KLEPPER. Yes.

The CHAIRMAN. There are studies, Dr. Klepper, that show otherwise. There is a Congressional Budget Office or a GAO study that shows that doctors have overstated the case for overmedicating and practicing defensive medicine.

Sometimes I do not know who is right about these things. We get such conflicting information on occasion. But I do not think there is any question that a lot of tests and procedures are ordered.

Now, before you do a procedure you usually have to call the insurance company and ask, "Are you going to pay for this?"

Dr. KLEPPER. Well, I think it is more than that, Senator. Speaking as a physician, a physician's reputation is his practice. And if a physician is hit with one or several malpractice cases, it is more than just the cost of paying the insurance. All of us that I know of, personally, went into the practice of medicine because we wanted to help people.

Over the last 10 or 15 years, the issue has become so sensationalized by the media and other people. In years past, what was an issue between the doctor and the patient and their attorney, nearly always is on the front page of our local paper.

It is an issue that affects everything that I do, and that all of my colleagues do. The nurses at our hospital every day have to fill out 10 or 20 forms for protection in case a patient sues them. They are often trivial things. They did not get their call light answered within 5 minutes, a medication may have been given at 11:05 instead of 11:10. But those nurses many times have to stay an extra hour just documenting things that may never amount to anything, but because of the potential that they might, they are just documented like crazy.

The same thing happens in our office. When I started practice with my partner 15 years ago, we had one insurance agent and two nurses between us. Now we have to have three people in the front office, and two nurses just for myself, primarily to handle the additional costs of administration.

You know, each insurance company has their own form. The majority of them, it is very complicated and expensive to get electronic billing set up, because you have to reformat your computer for every form. Even then it may only be sent in to a clearinghouse, which transfers that back to paper. I am getting off the malpractice issue a little bit, but I wanted to talk about the total administrative costs.

Our hospital has an RN training program, for example, and every 6 months to a year they have another set of 12 or 15 graduates. But I see many of them as patients, and they are quitting after a year or so because of the stress involved with fear of potential litigation.

The CHAIRMAN. I will close this panel with this point, and that is something along the lines of what you said, Dr. Hall, and I do not mean this as derogatory toward anybody. To be the only developed country on earth without national health care is unacceptable. And too many of us, including me, have a tendency to look at this, about how it is going to affect me, and not whether or not it is really good for the country. It would be good for the country if we can do it.

I will never forget the first time I went to the Soviet Union many years ago. This guy was trying to convince me that their system was so superior and so on. And one of the things he said was, "You know, our people do not have to worry about old age, they do not have to worry about medical care."

Incidentally, therein lay one of their problems, they did not have to worry about anything. That is the reason they did not work, because they got paid regardless—you know, that old story about, "We pretend to work, and they pretend to pay us."

But I never will forget that, and I thought, "there is a certain appeal about people not having to worry about how they are going to pay their health care bills." That is something that is coming, whether it comes this year or comes later, it is coming.

In closing, I wanted to mention to you, Dr. Klepper, the point you raised, that has never been mentioned before, and that is the anti-trust exemption. I think there is some merit in that. You have all spoken extremely well and were very helpful, and I thank you so much. Sister, it is so good to see you again.

Sister JUDITH MARIE KEITH. Good to see you, too.

The CHAIRMAN. Thank you all.

This is the last panel, and this is the public health sector.

Dr. Danny Proffitt, AHEC physician, Fayetteville; Kathy Jaggers, RNP, women's health practitioner, Russellville; Nancy Marsh, RN, administrator, Madison County Health Unit in Huntsville; and David Williams, administrator, Ozark Guidance Center in Fayetteville.

Dr. Proffitt, your name is first on the list, so please proceed.

STATEMENT OF DR. DANNY PROFFITT, AHEC PHYSICIAN, PUBLIC HEALTH MEDICAL CONSULTANT, FAYETTEVILLE, AR

Dr. PROFFITT. Thank you, Senator Bumpers. I feel like the hen in the fox house, here in this law building as a physician, but we——

[Laughter.]

The CHAIRMAN. Well, I may be the only lawyer in the room, so do not worry about it.

Dr. PROFFITT. They turned our medical school into a law school in Little Rock——

I come today to speak on health care reform, and how such reform might impact the practice of public health. In general, we are talking about health reform as it relates and translates to providing care to all of our citizens. There are other aspects to reform; that is, cost containment, quality assurance, and fraud prevention which has been discussed earlier today.

Yet there are more and more newer issues which are facing us that are going to be costlier, and that is: Costlier technologies and a burgeoning elderly population outstrip ever shrinking pools of funds, and a shrinking workforce that will fund our needs. This will force ethical and economic decisions that we have never faced before.

Through reform, we must first assure a basic level of care that does the most good for the most people. A strong public health policy should be the foundation to our reform, and to these guarantees.

I think for decades we have depended upon private physicians, and state and county health departments, and charitable institutions to provide all of our care, and no longer does that system work. Physicians and hospitals can no longer give away their care and services as they once did. The cost of providing care is highly competitive in this marketplace. Medical malpractice issues and societal demands prevent it.

Charity hospitals are not always available, as they are in some States, and these and other institutions are overloaded. They are also finding shrinking revenue base. Heavier indigent demands drain tax coffers, as Medicaid and other support programs have had to grow to meet the needs of our citizens. The increased numbers of the working poor have never been addressed, but hopefully will under the Clinton health plan.

Just as there is a limited amount of health care dollars, there is a limit of those who can provide the care at this time. Thus, we must become more efficient. Taxpayers and small businesses and others must demand efficiency and economy, and they must demand quality.

Quality must not be compromised. It is my firm belief that poor medical care is not necessarily better than no medical care. It does not help to be in need, and then not to have a place to go, or a time to get the needed medical care, and this increases cost in severe illness, which leads to greater intensity of service. Economy, and perhaps quality, go out the window.

To get economy and quality and availability, we must demand prevention. Goals must be set, however, and we must set in place preventive health measures that are proven to yield results, and not those that are just good bureaucratic ideas. Prevention is best done by true education. Again, we must use proven ideas and policies.

The current plan could put too much emphasis on unproven prevention and education plans which would drain precious dollars

that could be spent on the purchase of direct health services; that is, oral contraceptives, vaccines, tuberculosis, and HIV medications.

Cost and outcome data can easily be manipulated regarding prevention and education, making it appear as though they are more worthwhile than they really are. Expenditures in this area should be predicated on evidence that a demonstrated behavior change results from education.

My true belief—and this was mentioned earlier—is that the reform plan lacks in a critical area of public education, on how to care for basic medical illnesses and needs. My 15 years of experience reveals that there is gross ignorance by the public to know how to even treat a common cold, or to know when it is appropriate to seek medical advice. Our offices and emergency departments are filled with patients who should never have been there.

There must be a longitudinal curriculum of basic health education that is taught in primary schools K through 12 that empowers our citizens to be better stewards of our health care system. Countless millions, if not billions of dollars could be saved, in my opinion. Again, good education and good prevention are cost effective and last a lifetime.

The issues of economy, quality, availability, and prevention have long been the tenets of good public health policy. Let us continue to use public health as a backbone to promote health and wellness in our society. If we can use tax dollars for public health, and public health can be an efficient, available, and means of providing quality health care and disease prevention to large numbers of our citizens, then hopefully tax burdens will be lighter, and cost of health care lower. Economies of scale come into play here, and funds must be made available to ensure the core functions of public health.

One of those core functions of public health is data collection. We are in an information age, and there is a saying that, "He who has the data, wins." We must have the data; we must have it readily available and accurate. I believe that the Clinton reform plan recognizes this, and I would hope that this would be a strong point in the funding of public health to enable us to collaborate, collect, collate, and use data more efficiently.

We must also ensure the quality of our water, and monitor our environment. We have looming health issues, I believe, in the area of waste, waste management, water quality, air quality. As we become a bigger and more concentrated population, these issues are going to come up. Who is better placed to continue in these areas than the people that we have in public health, our sanitation people, our inspectors. We must have a heightened awareness for disease control, prevention, and detection.

This next issue is one that I feel some people may not be aware of, but an example is the looming new menace that is getting little attention, but which many feel will dwarf the HIV epidemic. I speak of the old disease of tuberculosis. This disease could easily get out of hand unless significant funding is allocated to health units to test, treat, and track persons and contacts of this disease. TB is not a sexual disease, and crosses all boundaries by the air we breathe.

TB was never contained until care was organized in a public health system. Multiple drug resistance is developing, and will

demand supervised medication administration. Medications must be available, they are expensive, and they have serious side effects. I believe that advice on TB management must come from multiple sources, and not just our Center for Disease Control.

At this time there are no resources to plan and organize a primary method for the TB explosion. I believe a Federal task force comprised of old TB clinicians, of which Arkansas has some distinguished people, health department heads, infectious disease specialists, pulmonologists, and lastly, the CDC is needed to guide us through this new problem of public health concern.

The CDC needs community, state, and regional input before embarking on edicts on how to carry out care in this area. Again, some believe there is an overreaction to the HIV/AIDS epidemic, and an under-reaction to the coming TB problem.

Policy and system development, leadership training and education of public health professionals, the provision of lab services, the assurance of accountability and quality, and public information and education are all other core functions that I believe are being adequately addressed. We should make sure that these are truly funded, and that we get the due attention that we need.

There is a feeling that there will be less direct patient care given by public health with health care reform as more people are covered, and we need to make sure that we do the best job that we are capable of doing in the areas that are the true core functions.

One thing we must allow is autonomy of our health units to define and then meet needs. For these reasons, funds must be made available that are pliable. We have many funds that are mandated on how they are used, and we have no way to take those funds and use them on a community basis. We need less mandates from the Federal bureaucracy, and even from the State, to allow innovative ideas to come forth. I think that this will, in turn, foster collaboration within communities and regions to address the needs of those particular areas.

A particular example, Senator, is how we have gotten local hospitals in our area to help work with our local health unit to fund practitioners and clerks, that have enabled us to have a timely prenatal care clinic.

Our waiting list was in the 80s and 100s at one time, and through help of physicians and one of our local hospitals, funding was made available for a practitioner and clerks, so that the waiting list now is either zero or minimal. These people are getting early prenatal care, and hopefully we are saving dollars.

The care is judiciously given. We believe the quality is there, and we feel that all of our patients have been getting what they have been asking for. We know that data available shows that prenatal care, for every $1 spent, saves $4. And that is what we are trying to do, if we can get that kind of economy.

Last, we need funding to allow our clients availability to public health. We need night clinics, we need weekend clinics, we need transportation, and child care. As you said earlier, if the people work from 8 a.m. to 5 p.m., and the clinics are open from 8 a.m. to 5 p.m., then that care cannot be available.

Prenatal care is important; family planning is important. A statistic that I was given was that immunizations, for every $1 spent,

saves $10. I would like to invest my money that way. Mothers and workers and many employers will not allow time off to go for these services, and most cannot afford to take off work, if they were allowed to be off. Thus, an unplanned pregnancy results from lack of contraception, a prenatal visit is missed, an immunization is not given, and the costly cycle repeats. With that, I will conclude my remarks.

The CHAIRMAN. Thank you very much, Dr. Proffitt.

Kathy?

STATEMENT OF KATHY JAGGERS, RNP, WOMEN'S HEALTH PRACTITIONER, AREA 3 HEALTH OFFICE, RUSSELLVILLE, AR

Ms. JAGGERS. I am a women's health nurse practitioner with the Arkansas Department of Health. All of my care is given in public health clinics.

I serve eight counties in Arkansas, and supervise nurse practitioners in other parts of the state. I treat many minor illnesses in women of childbearing age, such as ear infections, tonsillitis, anemia, bladder infections, and sexually transmitted diseases.

I would be happy to treat males and children, and stay after hours, if I could get the funding. Mrs. Phillips on your first panel talked about seeing patients in the Clarksville hospital. We have a clinic a block away from there that I can only go to one day a week. I would love to stay after hours and see other patients. I mainly serve low income, indigent, and uninsured populations.

Why are we here today? To contain rising costs of health care, and to improve the access to quality care for everyone. I think this can only be done if we form a union of two components: If we use the medical care system as it presently is now, and combine it with the public health system, much as Dr. Proffitt has talked about.

In the past, health care has emphasized treatment of medical conditions, and public health has targeted whole populations and their daily living conditions. I think that many of these functions do overlap. Each has its unique contributions, but we have to combine these to serve our hard to reach and high risk target populations, for whatever reason that they are high risk. Perhaps it is a lack of transportation, lack of income, lack of education, or they have a chronic mental or physical disability.

One of my largest concerns is the availability of providers, and the geographic barriers to care. In Arkansas, there are 61 primary care health professional shortage areas; 29 of these cover entire counties; 71 out of our 75 counties in Arkansas are considered partially or fully medically underserved.

One of the solutions that I have seen, and would like to have more done with, is using mid-level care providers, advanced practice nurses or nurse practitioners: advanced practice nurses are nurse practitioners, clinical nurse specialists, certified nurse midwives, and certified registered nurse anesthetists. The Arkansas Department of Health has 96 local health units, 38 satellite clinics, and 24 school based clinics.

The CHAIRMAN. Now, repeat those numbers again.

Ms. JAGGERS. There are 96 local health units in the state; 38 satellite clinics, and 24 school based clinics. All of these units are

staffed by 45 registered nurse practitioners and 2 nurse midwives, who provide most of the care that is given. These nurse practitioners are traveling around from county to county, as I do.

These mid-level care providers manage most of the care in fiscal year 1993 for 48,000 child health patients, 16,000 maternity patients, and 68,000 family planning patients, so you can see that most of us carry a very heavy load and travel a lot.

Not only did we see patients in clinics, we went out into the homes, along with many public health nurses, and saw over 1.2 million home visit patients, providing personal care. Most of them were frail, homebound, chronically ill patients, but some were maternity patients or patients in their early postpartum periods.

These pregnant patients are extremely important to us, because the home visits help enhance the prenatal care. It prevents future health problems, and it provides anticipatory guidance for infant care.

Our home assessment visits offer much education and support, really getting in there and preventing problems before they occur.

Many of our patients are young, they have never had children before, and they do not have a good family support system. So, our public health nurses can get into homes, provide guidance in teaching, and perhaps prevent child abuse or some of the violence that is occurring in the homes. And I truly believe that if we can prevent some of the family violence and abuse, that that could be one of the most important contributions to our health care for many of our patients.

We need more of these personal care services for the hard to reach populations, those who are a threat to the public health, or unable to access care, even though they qualify for that care or those services. One example could be a chemically dependent person with active TB, who may be homeless, and who has not sought medical care. Someone needs to go out, track them down, give them their medication, and get them into the other medical services that they need.

We also have many high risk or potentially high risk families in Arkansas, whether they are low income, racial or ethnic minority groups, or individuals with disabilities. We have many individuals with complex needs that require additional services.

One example would be a 16-year-old pregnant female who lives with her unemployed mother or her grandmother. She has been physically or emotionally abused. She has dropped out of school, abuses alcohol, smokes heavily, and does not come to the clinic for her prenatal care. A public health nurse going into that home is invaluable, just helping her and getting her the care that she needs.

That person would be a prime candidate for pre-term labor, having a baby before it is due. It costs an average of $50,000 before a low birth weight baby can leave the hospital. If we can just prevent even a few of those pre-term babies, we can save a lot of money in the prevention. We need more of these home visits to prevent these types of problems, and to safeguard our families' health.

We need more nurse practitioners to go into the homes, to serve these rural health clinics. Nurse practitioners are accessible, they

can staff the clinics, they are in many of the private clinics you have been talking about all day. They are cost effective. They work towards health promotion and disease prevention with the medical system. I would like to see a nurse practitioner put in every health unit, so that we can have them there every day, seeing the clients that we need to see.

Specifically in my area, Area 3, which goes from Scott County all the way back to Faulkner County, I only have four counties out of those eight that have physicians in them who will deliver babies. So my prenatal care patients have to travel across counties to find someone to deliver their baby. Not to give them prenatal care.

Many of the physicians will not see patients from another county. They will deliver them when they drop into a hospital, but they will not provide the prenatal care. So the health department is providing the prenatal care, the patient is traveling across county, and she may not have transportation. She may end up calling an ambulance to come and get her and take her to a hospital to deliver her baby.

Many of the hospitals will not take payments for services from the health department, so we end up overloading one source more than another. I cannot find local backup for simple patient treatments in counties for many of my maternity patients, because the doctors do not deliver babies anymore, and the hospitals do not allow deliveries in their hospitals. I would really like to see more cooperation from local physicians. That is all.

The CHAIRMAN. Good statement, Kathy.

Nancy?

[The prepared statement of Ms. Jaggers follows:]

PREPARED STATEMENT OF KATHY JAGGERS, RNP COORDINATOR

PUBLIC HEALTH AND HEALTH CARE REFORM

Introduction

This paper was formed in part by combining many excellent contributions on Health Care Reform from authors in the Arkansas Department of Health, primarily Nancy Kirsch, Bureau of Public Health Programs Director, and Richard Nugent, Bureau of Public Health Programs Medical Director.

The primary goals of health care reform are to contain the rising costs of health care and improve citizens' access to quality care. The importance of those goals cannot be overstated. However, many of the most pressing health problems that Arkansans face will not be addressed by improvements in those areas, along. Just as clean food, water, and sanitary living conditions were major contributors to improved health status of the population in past years, future gains will depend on society's ability to modify behavioral risks and address social problems not exclusively responsive to improvements in health care delivery. Tobacco use and exposure, substance abuse, environmental toxins, injury and violence, infant mortality, hunger and poor nutrition, and many other factors adding to health problems are intimately intertwined with a variety of social problems for which there are no easy solutions. While improvements in health care which lower costs and improve access to quality care will benefit all of us, additional preventive and mitigative measures are needed to improve the overall health status of Arkansas.

A reformed health system can be viewed as the union of two components—the health care delivery subsystem and the public health subsystem. In the past, health care has emphasized the treatment of medical conditions, while public health has targeted whole populations and their daily living conditions. Each performs some functions which seem to be within the purview of the other, yet each has a unique contribution to make in improving and maintaining the health status of the population. It is through the combined contributions of these subsystems that improvements to the overall health status of Arkansas citizens can best be achieved. They

do, and must, complement and interact with each other. Together, the two can produce a more efficient, more effective health system that will improve the health and quality of life for all Arkansans.

In Arkansas, public health service includes the assessment of health status and needs, development of public health policy, promotion of community-based systems of preventive and primary car, enforcement of regulations for environmental health protection and assurance of quality care, and provision of quality services. An example is a 16-year-old pregnant teenager, who lives with her unemployed single mother, has been physically and emotionally abused, has dropped out of school, abuses alcohol, smokes heavily, and misses most of her prenatal care appointments.

Because of their life circumstances, members of these populations often do not access the health care delivery subsystem until their health needs have escalated to the point where they require costly medical intervention, often on an emergency basis. They consequently experience above average incidences of disease, disability, and death. These populations need assistance to obtain primary health care services, and need individualized health promotion services and social services to improve their health status. They frequently require extensive outreach and service coordination to integrate delivery of required services, follow-up to ensure compliance and return visits, and assistance in modifying high risk behaviors. These services must be linguistically and/or culturally-appropriate in order to be effective.

The ADH Prenatal program recently began home visits for patients during pregnancy and the post-partum period. These personal health promotion services are designed to enhance prenatal care, prevent future health problems and provide anticipatory guidance for infant care. For example, when conducting a home assessment visit, a public health nurse may provide education and support to parents who are at risk of neglecting and abusing their child because they have a limited understanding of child development or positive parenting. These personal health promotion services can ultimately influence community norms and are an example of public intervention for the primary prevention of violence. The prevention of family violence and abuse may well be one of the most important activities in raising the health status of certain high-risk or potentially high-risk populations.

Many more programs of this type are desperately needed in Arkansas. True "home health" visits, putting the public health nurse in the home, could help provide for the health education, counseling, outreach, and enabling services needed by our low-income, underserved, hard-to-reach and otherwise vulnerable populations.

Even if these services are eventually covered by the health reform plan, many of these patients will still lack ready access of health services. In order to provide "universal access", health reform must address not only financial issues, but issues such as availability of providers and geographic barriers to care. In Arkansas, there are 61 primary care health professional shortage areas, 29 of which cover entire counties. Moreover, 71 of Arkansas' 75 counties are considered partially or fully medically underserved.

Public health agencies have experience in meeting the unique needs of low-income and hard-to-reach populations. Thus, while many of the personal health care services now provided by the Department of Health will be reimbursed by the new system, public health clinics will continue to be critical in meeting the needs of patients when:

—services are not covered by the health care reform plan;
—persons are not covered (such as non-citizen residents;
—areas are without adequate local health care providers;
—services are not available from local health care providers.

Health Care Delivery Subsystem

The primary responsibility of the health care delivery subsystem is clearly the effective management and provision of high quality health care, at an affordable price, to all who need it. A managed competition model must be formed to provide a comprehensive set of personal health care services to all enrolled persons, including those who are hard-to-reach and whose lives are complicated by factors such as lack of transportation, income, education, or chronic mental or physical disabilities. The managed competition model must not only be accountable for the health of the enrolled populations, but must also be accountable for the achievement of public health goals and therefore undertake a broader array of population-based activities. This will further involve the health care delivery subsystem in areas beyond the traditional delivery of medical care, and to solicit consensus on public health goals between the public health and health care delivery subsystems.

Success of the managed competition model in part relies on a sufficient supply of providers to complete for a sufficient supply of patients. Such is not the case in all

of Arkansas. There is one physician for every 714 people in Arkansas, as compared to one physician for every 413 people in the United States. More than one-fifth of all Arkansans live in areas designated as health professional shortage areas. Moreover, Arkansas is sparsely populated and rural, which makes for some very small markets of patients. The population density of Arkansas is 45 people per square mile, as compared to 59 people per square mile in the United States. And the population density varies from a high of 455 per square mile in Pulaski County to a low of 9 per square mile in Calhoun County. Of the total State population of 2.3 million, 52 percent live in urban areas (places 2,500+) as compared to 74 percent urbanization for the United States (Arkansas Department of Health, 1993; PC Globe 1992).

Nurse Practitioner vs. Physician Care

A recent study, conducted for the American Nurses Association, found that nurses provided more health promotion activities than did physicians and scored higher on quality-of-care measures. Some 60 percent to 80 percent of primary and preventive care traditionally done by a doctor can be done by a nurse for less money. This is not to say nurses work cheaper, but their cost-effectiveness reflects a variety of factors related to the employment setting, liability insurance, and the cost of education. Preventive and primary care does not require the expensive specialization that characterizes physician education today.

The advanced practice nurse (APN) is an umbrella term given to a registered nurse (RN) who has met advanced educational and clinical practice requirements beyond the 2-4 years of basic nursing education required of all RNs. Under this umbrella fall four principal types of APNs: Nurse Practitioner, Certified Nurse Midwife, Clinical Nurse Specialist, and Certified Registered Nurse Anesthetist. For the purpose of this paper, advanced practice nurse will indicate the nurse practitioner role.

Nurse practitioners are accessible. They provide pre-employment physicals for employers, home health care to the elderly, health education in hospitals, schools, and community clinics, geriatric care in nursing homes, infectious disease control in prisons, pre- and post-natal care in inner-city and rural clinics, and psychotherapy in public and private practices.

Nurse practitioners are not low-priced doctor substitutes. They are first and foremost registered nurses, a profession with its own educational and licensing requirements, regulatory oversight by Boards of Nursing in all 50 States, and competency standards and continuing education requirements. NPs are skilled in performing a wide range of initial, or primary, health services—especially screening and preventive services—that, if ignored, can lead to far more serious and costly health problems down the line.

If advanced practice nurses are so accessible and affordable, why don't we use them to help provide care to 60 million uninsured and underinsured citizens? A study published in the Yale Journal on Regulation by Barbara J. Safriet, associate dean of the Yale Law School, addressed that question. "Unnecessary restrictions on their scope of practice, prescriptive authority, and eligibility for reimbursement actively impairs these providers proven ability to safely meet the health care needs of many of our neediest citizens," Safriet said. "Removing these barriers would be an important first step to restoring the focus on health, and on care, that our systems so desperately needs."

In the Arkansas Department of Health, nurse practitioners currently provide child health, prenatal health, and family planning services. The nurse practitioners focus on primary and preventive health care, providing physical examinations and prenatal care, treating illnesses like colds and infections, and providing family planning methods. More nurse practitioners are needed in Arkansas, especially in the rural areas. NP retention and recruitment for ADH has been difficult due to heavy clinical loads, extensive traveling to and from rural clinics, and low salaries.

With the shortage of primary care physicians and their reluctance to work in rural and other underserved areas, it is time to provide more support than ever to nurse practitioners. With an emphasis on health promotion and disease prevention and a proven record of providing excellent primary care in diverse settings, nurse practitioners form a critical link in the solution to America's health care crisis. Removing the barriers to advanced practice nursing would pay a health dividend now and in the future. In order to assure this future, Health Care Reform legislation must include the following basic elements:

—quality management with a multidisciplinary approach to the evaluation of the effectiveness of care, practice standards and guidelines, and outcomes research,

—a focus on primary and preventive health care,

—a revitalized public health system,
—nurses recognized as qualified health care providers and eligible for reimbursement by public and private payors,
—Federal override of restrictive state nursing practice acts,
—anti-discriminatory language to enable true competition among providers,
—parity in Federal educational subsidies for nurses as primary care providers.

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STATEMENT OF NANCY MARSH, RN, ADMINISTRATOR, MADISON COUNTY HEALTH UNIT, HUNTSVILLE, AR

Ms. MARSH. I work with the Madison County Health Unit in Huntsville, and I am here as two things: One is as a health department employee. I am also a nurse practitioner, but I do not work as a nurse practitioner. I'm also here as a resident of a rural county that has faced a recent health crisis. I look forward to health care reform fixing some things, instead of just causing more problems.

I am in a one-nurse county, so when people come into the local health unit for any services, they are going to see me day after day. Thus I have sort of developed into a resource person for the people of Madison County.

Madison County has a rural population of about 11,000, whose local hospital closed its doors last year. It was a 75 bed facility. It was built about 10 years ago; that had to close due to local physicians not wanting to live there, and being mismanaged from a business standpoint.

At the same time, all the physicians who were practicing left the Huntsville clinic. Since that time in the last 2 years we have had part-time physicians who have been employed by a hospital, retired physicians who are helping, or different physicians who are floating in and out every day of the clinic.

The majority of the time patients can be seen for medical care, but some days, regardless of your ability to pay, whether you are private pay, have insurance, whatever, there is not a physician there for you to see that day. Some days of the week there is not a physician at the local clinic to be seen.

So then, people are looking for answers and trying to find out who they can go see. They can travel 30 miles to Berryville, to Fayetteville, or to Springdale, but a lot of people face a problem with transportation. They are sick already. Especially if they are elderly or do not drive, then they have to try to find someone who can

take them to another clinic. The closest hospitals are also 30 miles away.

Health care reform has looked at the alliances, and my concern is how far away is the source of your care going to be. How many miles are we going to have to travel to get to who is in our alliance? Such as the HMO system in Arkansas, the closest place is Little Rock, which is 3 hours away. That is a real concern, when you live in a rural community, about how far away our access to care will be.

Arkansas has the second highest teenage pregnancy rate per population in the country. Madison County is one of those designated counties in Arkansas that has a high rate of teenage pregnancies per live births. A chronic problem that I see almost daily, is there is no local source of prenatal care.

None of these physicians in this clinic treat prenatal patients. There is a crisis in northwest Arkansas now to get prenatal care, whether you have insurance, a Medicaid card, whatever source you have. There are certain physicians who will see patients, and some who will not.

Someone mentioned crossing county lines. We cannot get Madison County prenatal patients in a Washington County health unit due to physician backup. So we have people that I talk to probably once a week or once a month, that I cannot get into any source of prenatal care, regardless of their ability to pay.

That is a concern to me when you talk about being part of a health alliance; can we still get them into a source of prenatal care? You look at the high teenage pregnancy rate, along with not being able to find a source of prenatal care, then they deliver early, and the result is you have an accelerated hospital cost because of pre-term labor and no prenatal care.

Northwest Arkansas now has, in the past year, a large Mexican population working in the poultry plants around here. According to the health care plan, the way I read it, these people will not be eligible for the alliances, because they are not true Americans. Once again, who will provide their care? They still have health needs, they still are having babies, they still are getting sick, they still have families. And that is a concern to us, where is this part of the population going to go for health care?

Arkansas needs more funding for health education starting with kindergarten through 12. Right now there is some limited health education being done in the schools, depending on which school you are in and how much funds they have. The Arkansas Department of Health, when they see their patients, do a lot of health education and patient education, but there is no mandated health education.

We have all talked about preventive care and risk behaviors, and it needs to start at a lower level and needs to be some kind of funding for that. I am not sure how that funding will be in the future where that funding source will come from.

The Clinton health plan looks at public health service as providing less direct patient care services, and more time being spent in serving what are classic or historic public health functions of protecting the environment, investigation and control of disease, public information and education. Concern for Arkansas is the

funding for these public health services, whatever they will be, whether we are in direct patient care, or whether we are into doing more of the data gathering and more of the tracking down of patients.

The current health department state budget is tight now. We get some funding from our Arkansas state legislature. We get additional funding from other sources, such as immunization grants from CDC, Title 10 funds for family planning.

There are so many positions that are currently in the Arkansas Department of Public Health that do not come under a billable service. You do not get reimbursement for the amount of time it takes you to track a communicable disease patient, or how much time it takes you to track a tuberculosis patient. Whereas, in the private sector, the provider sometimes can route those into their cost per patient, the Arkansas Department of Health is limited on how we can fund different positions.

Such as the outbreak of measles in 1985, there was no extra funding that we could dip into, but we had to use more people and had to get more vaccines. It just puts a crunch in the current budget.

If the Arkansas Department of Health does change from the functions that we are doing now, such as a lot of direct patient care, and more to data collectors, statistics, doing more disease process management, there is a concern that: Will there be adequate time to switch from one type of health department services to another? It is like by 1995 or 1996 you have to have a plan and program in place. Will there be duplicate funding whereas we can continue to finalize and get rid of the things we are doing now, plus other funding for us to cross-train these people and get them ready into their new roles? I think, a lot of the questions for us is about funding, since we are so limited on where our funding sources come from.

Right now we provide direct patient care to patients who fall between the gaps in the private sector. There are people who are not eligible for certain programs, they do not have access, and so we have to see those people. Home health and maternity care are two examples of this. I think there will still be gaps in the new health care plan for patients who do not qualify for health alliances or cannot find access to care.

I think having nurse practitioners in rural health clinics is a good idea. That is probably a personal bias of mine, living in rural Arkansas and being a nurse practitioner. Also I think the Area Health Education Centers clinics' concept needs to be expanded. They are training young doctors to work in rural areas of Arkansas, they are giving them hands-on experience of how those things are, and I just think that is one area that could be expanded.

I have a lot of questions, more than anything, about where are we going and where is the funding going to come? Thank you.

The CHAIRMAN. David, please proceed.

[The prepared statement of Ms. Marsh follows:]

PREPARED STATEMENT OF NANCY S. MARSH

I work as a public health nurse/administrator in Huntsville for the Madison County Health Unit. This is a one nurse county health unit where I do various clin-

ics each day. So the people who utilize the health department for different services such as immunizations, the WIC program will still see me as the nurse even if they come on different days. I have also worked in hospitals across the State and in South Carolina.

Madison County is a rural county with a population of 11,000 whose health care has had a recent crisis. Huntsville Hospital, a 75 bed facility closed its doors last year. Huntsville has had trouble recruiting a full time physician to practice here. People have trouble finding a doctor to see them for their health care needs regardless if they have the ability to pay. Cities like Fayetteville, Springdale, Berryville are able to see the people of Madison County but a larger number of this population have trouble finding transportation to a neighboring city. The closest hospitals are 30 miles away. If health care reformed used HMOs the closest HMO hospital is Little Rock which is 3 hours away. Luckily Madison County has a very good EMS.

Arkansas has the highest (or second highest) teenage pregnancy rate/population in the county. Madison County is one of those counties in Arkansas that has a high teenage pregnancy rate per live births. There is no local source of prenatal care for Madison County. This is an example where the private sector can't meet the health needs of its people. There is currently a crisis for prenatal care in northwest Arkansas. Even if you have a Medicaid card, you are limited on where you can be seen for care. I still see about one patient a month who we can not find a source of prenatal care. This just compounds the problem of no prenatal care leading the increase costs of infants in Intensive Care Nurseries.

Northwest Arkansas has a large Mexican population who are working in the poultry plants. According to the Health Care Reform these people will not have access to the regional health alliance. Who will provide their care? If no one, then again the costs increase in tertiary care centers.

Arkansas needs more funding for health education—starting with kindergarten in school. Lets help future generations. Schools now have recommendations of health education but there are no mandated health education. Due to funding sources, some schools offer a comprehensive health ed program and some schools say they offer it but no one regulates what is being offered. Sometimes I wonder if an outside agency such as the Arkansas Department of Health doing Health Education in the schools wouldn't be more effective and comprehensive for the youth of Arkansas.

The Clinton Health Care Plan looks at Public Health Services providing less direct patient care services and more time being spent in serving the "classic" public health functions of protecting the environment, investigation and control of disease, public information and education.

Arkansas needs to be concerned about funding for our public health services whatever they will be. Our current Health Department state budget is tight. The Arkansas Department of Health gets additional funding from other sources such as immunization grants from CDC and Title X funds for family planning. There are so many positions currently in the Arkansas Department of Health that don't come under a billable service—the environmental program, TB, tracking of communicable disease patients, outbreaks such as the measles in 1986. Where will the funding come for an increase in services that are not billable?

If the Arkansas Department of Health does change functions from direct patient care to more of managers and data collectors, will there be adequate time to switch from one type of organization to another? Will there be duplicate funding while we finish patient care services while cross training for the newer roles and functions?

Arkansas needs the Arkansas Department of Health to provide direct patient care services now. The Health Department does not need to be in competition for services but has historically filled in the "gaps" of health care from the private sector—home health and maternity care are two examples. There will still be gaps in health care from those patients who don't qualify for health alliance. Arkansas may always need the Arkansas Department of Health to provide patient services to some patients. Future funding is the big question. There are so many good things the Arkansas Department of Health provides now that could be expanded to serve more people in Arkansas except for limited funding for staff positions. I think nurse practitioners in rural health clinics is a good idea to provide health care to rural Arkansas. I think the Area Health Education Center concept needs to be expanded.

This has been examples of states needing local control of the Health Care Reform. Arkansas is so different from other states. The Clinton Plan for Public Health as it is written sound good on paper but not practical to Arkansas. I hope to see problems with our current health care system helped or improved upon by a health care reform.

STATEMENT OF DAVID WILLIAMS, ADMINISTRATOR, OZARK GUIDANCE CENTER, INC., FAYETTEVILLE, AR

Mr. WILLIAMS. Thanks.

First of all, Senator Bumpers, thank you for sponsoring this forum, and thanks for the chance to talk about mental health reform in the middle of all this health care reform. Thanks also for a career of helping physical and mental health get better in America. I would not be here today if it were not for you.

I am going to speak to you from the perspective of being an administrator of a private, non-profit corporation that provides mental health care in these four counties here in northwest Arkansas.

We see about 6,500 people a year for some treatment of mental disorders. We carry about a tenth of the load of the mental health centers in Arkansas who see about 65,000 people a year, many of them with long-term chronic disorders.

The CHAIRMAN. Are you saying you see 10 percent of all the people who are seen in the state?

Mr. WILLIAMS. No, just in the mental health centers.

The CHAIRMAN. OK, that is what I am talking about.

Mr. WILLIAMS. Well, for the mental health centers. And we carry the predominant load of specialty mental health care.

What we have developed up here, just so you will have the perspective, we have the only ambulatory base system in Arkansas that is accredited by the Joint Commission on Accreditation of Health Organizations. And we have developed a continuum of care ranging from very low cost, least restrictive alternatives of education and outpatient, through partial hospitalization, case management, residential emergency.

We then have our own in-house inpatient care, and work with a local hospital for a lot of adult inpatient care. So we are probably the closest thing to a mental health HMO that you will find in Arkansas, though only about a fourth of our revenues are capitated. We deal a lot with insurance companies, and we deal a lot with privately insured and self-insured businesses. It is kind of a mixed bag.

I would like to share some perspectives about this whole thing. With your permission, I will just highlight my written testimony,——

The CHAIRMAN. Please.

Mr. WILLIAMS. —and try to conserve some time.

The big picture perspective is that we cannot afford to keep spending more than any nation in the world on health care, and get less than the healthiest people in the world in return. What we believe we need is the kind of large scale health reform that turns our health status, as well as our health economy, into economic and social assets, instead of continuing the current state where they are increasingly becoming economic and social liabilities.

We believe that we have to have the kind of health status and the kind of health economy that gives us a competitive edge in the world marketplace, and leads to higher quality of life here at home. It is a matter of cost management of both our health and

our health economy, replacing the failed policies of cost containment of the 1980s.

What we think we need is to change from a history of health expenditures, into a future of health investments. From the standpoint of the mental health part, that means we have to change the financial incentives, because we cannot afford the ones that are in place. I would like to highlight the three biggest ones that have the most to do with our system failure and our relatively low mental health status.

First of all, we cannot afford the incentives not to treat most of the people who have a mental illness or disorder in America. That is a third of us in 1994. That is half of us in our lifetimes. By anybody's studies, the most conservative studies, less than half of us who need treatment in any given year get it. For children it could be as low as a third; for adults, as low as a fourth.

We cannot afford that, because we have over $200 billion a year in lost worker productivity due to mental illnesses and disorders.

The CHAIRMAN. $200 billion?

Mr. WILLIAMS. In lost worker productivity, criminal justice expenditures, and mortality due to those illnesses. Those three in combination, over $200 billion a year. If we do not do the treatment we need to do, that is going to continue to go up. Those costs do not even count the cost of work place accidents, equipment damage or worker replacement. They do not count the school failures, they do not count the pain and grief of victims of those diseases and their families, and the cost of those lives that have been disrupted, injured, and lost. They are just straight economic indices of the cost of mental disorders to our economy. This does not even count the cost of treatment. When we know that eight out of ten are likely to improve with appropriate care, we cannot afford to continue incentives not to care for more than half who need it.

The second reality is that we cannot afford our incentives not to treat in the most cost effective manner possible. Over 70 percent of our mental health expenditures in America go for hospital based care to only 7 percent of the people who get treatment in a year.

Between 75 and 90 percent of the mental health insurance claim dollar is for hospital based care. We cannot afford this bias for inpatient coverage, when our research and experience shows us that 50 to 80 percent of patients could be treated just as effectively, or more so in many cases, in ambulatory settings.

Third, Senator we cannot afford our incentives to drive physical medicine costs up by not attending to mental conditions. About half of the visits to primary and specialty physicians' offices are for conditions that have no identifiable biologic basis. Cost offset studies have revealed an average of 20 percent physical medicine cost savings a year after appropriate treatment for mental and substance abuse disorders. And I have seen the range of those studies from a minimum of 5 percent cost offsets, to a maximum of 80 percent with some conditions. These are dollars being spent on physical medical care that were unnecessary had there been appropriate mental health care.

Those costs do not count things such as how highly correlated post-heart surgery deaths are with depression, or how many emergency room traumas for accidents or violence are byproducts of un-

treated mental conditions. We simply cannot afford to not treat mental health care appropriately because of how much it drives up our physical health care costs.

To summarize those three points, we cannot afford a system of incentives not to treat, not to treat cost effectively, and not to treat the mind in support of the body's total health. I believe that all the actuarial studies that project costs of mental health benefits based on these outmoded past incentives are flawed, because there is no way we can afford to continue the incentives of the past.

The key to mental health reform in health reform is to get the incentives straight, and change the future. I believe we can do this in four ways. First, by providing comprehensive universal coverage for mental health services, coverage that is equitable, accessible, and on par with physical health coverage. That means if the physical health coverage is 80/20, the mental health coverage ought to be that, too. That means no lifetime limits on mental health that are artificial, any more than lifetime limits on physical illness.

A second thing we can do is shift the incentives from the hospital based system to an ambulatory based system. That means things like no more 80/20 co-payments for hospital mental health care, and 50/50 co-payments for outpatient or ambulatory care. It also means a wide variety of substitution of ambulatory benefits, such as partial hospitalization when they are known to work, for the more costly hospital care.

A third thing that we can do is reward lasting outcomes, instead of everlasting procedures. We need capitated models that reward and provide incentives for people brought to levels of good mental health and maintained, to prevent relapse management, and to prevent deterioration.

A fourth thing that we can do is reward organized care systems that integrate and coordinate patient care for the best physical and mental health outcomes, and make sure that those organized systems have strong mental illness prevention, mental health promotion, and long-term care components.

We need team work and reintegration between the physical health and the mental health practitioners, and the doctor who talked awhile ago about needing more credit in primary health care for cognitive valued physician care is right on target with one way that we could do that.

Briefly, let me say that the Washington Business Group on Health has documented a wide variety of businesses who have led the way in providing these kinds of unlimited comprehensive mental health coverages with 80 to 85 percent coverage, and incentives for ambulatory care, and they have found it pays.

To sum it up, you would recognize names like IBM and Chevron and First Chicago, and a lot of others. What they have found is that when they switched mental health incentives, they produced trends in cost savings and positive outcomes that are great guides for mental health benefits structures of the future.

For example, McDonnell-Douglas saw appropriate utilization go up, and per capita mental health expenses for their entire covered work force go down with this model. First Chicago saw, for 6 years straight, only a 3 percent increase in their total mental health costs for their entire work force, and this was at a time when medi-

cal hyperinflation was twice the consumer price index, and they basically went to these models where they got more people covered and treated with more appropriate care and had substantial cost savings.

I know local businesses who have had similar experiences through Employee Assistance Plan contracts with us, and I think that the benefit system should create the opportunity for all businesses, large and small, to buy into this kind of comprehensive, cost effective, outcome based, ambulatory mental health care.

It is my belief that if Congress or the market switches the incentives, the focus of mental health care financing will switch from harvesting billings to value-based competition for the best care and the best outcome buys. That will lead to a more cost effective system, and to better mental health in our population. Cost management, if you will, of our mental health status and our mental health share of the economy.

As the returns on our investment of 13 mental health dollars on every health dollar invested in America come in, we will reap a dividend that will help us in the world marketplace, and help us at home. We will appreciate anything and everything that you can do to switch the incentives in that direction. Thank you.

[The prepared statement of Mr. Williams follows:]

PREPARED STATEMENT OF DAVID L. WILLIAMS, PH.D.

Thank you, Senator Bumpers, for this hearing and your long-term work for health care, as well as the opportunity to testify about the crucial need for mental health care reform as part of our overall system changes for the better. Your historical support and advocacy for quality community mental health services has contributed significantly to my being able to speak to you today from the perspective of one of the stronger private, not-for-profit provider organizations in one of the nation's stronger State-wide mental health systems. I thank you for that too.

From our perspective, the "big picture" is that we cannot afford our current national health status or health delivery and financing system. We cannot afford to spend more than any nation in the world on health care and get less than the healthiest people in the world in return. Our health status (relative to other industrialized nations) and our health economy are drains on our total economy and drags on our dream for high quality "life, liberty and . . . pursuit of happiness" for all Americans. With each year of escalating costs and lagging health status, they become growing social and economic liabilities.

What we need is the kind of large scale health reform that turns our health status and our health economy into social and economic assets. We need both improved health status and efficient health economy in order to foster our nation's social and economic development and give us a healthier competitive edge in the world marketplace. We need to change from a history of health expenditures to a future of health investments.

For the mental health part of health reform, this means we cannot afford our current systems' of failure to treat most persons with mental illnesses and failure to treat in the most cost-effective manner possible. This month, University of Michigan researchers confirmed that, "Almost half of Americans experience mental illness in their lives and almost a third are afflicted in any one year." [1] Yet we fail to treat at least a majority and may as many as 70 percent of those who need it. The direct economic costs of these disorders is over 273 billion dollars a year and 76 percent of this is due to lost or reduced worker productivity, criminal justice expenditures and mortality. That does not even count the additional costs of work place accidents, coworkers reduced productivity, equipment damage, school failures, worker replacement, much less "fully account for the personal pain and grief experience by the victims of these diseases or for the lives that have been disrupted, injured or lost.[2] When we're likely to get improvements for up to 80 percent of people treated, these losses and costs of neglect seem unbearable socially and financially.

We cannot afford the inefficiency of our bias for inpatient coverage of mental health care. Seventy percent of our annual mental health treatment costs are for

hospital-based treatment for only 7 percent of Americans getting treatment in the public and private sector and inpatient charges comprise 75–90 percent of the mental health insurance claim dollar. We know from research and experience that 50–80 percent of the people customarily treated in inpatient settings could be treated just as effectively or more so in outpatient or partial hospitalization settings at greatly reduced cost. We can't afford for the thirteen mental health cents of every health dollar spent in America to be so cost-defective and inefficient.

We cannot afford for our deficit in necessary mental health care to keep inflating other primary and speciality health care costs. About half the visits to physicians are related to patient problems that have no identifiable biologic basis and a summary of 25 cost off-set studies revealed an average of 20 percent physical medical cost savings a year after treatment for mental or substance abuse disorders. This does not count the impact of such recent findings as last week's news that extended depression after heart surgery is highly correlated with post-surgical deaths. It does not count that part of hospital emergency room trauma treatment made necessary by accidents or violent acts resulting from untreated mental disorders.[3]

In short, we cannot afford not to treat and we cannot afford to continue financing mental health services with an inpatient bias. I am told that the major reason for mental health benefits being reduced in the President's Health Security Act proposal is that actuarial studies over the last 10 years are being used to demonstrate that mental health coverage on part with physical health coverage is not affordable. I would suggest that if those studies are based on projections of doing mental health services the same old way for the next 10 years, they are right.

But, I wonder if these studies could be seen as evidence of the need for reform of how we provide and pay for appropriate and cost-effective mental health services in America. They could be illustrations of how a past of wrong incentives has been compounded and projected into an unaffordable future.

The key to mental health reform in health reform is to get the incentives straight and change the future. We can do that in four ways: [4]

First, make medically and psychologically necessary mental health services as accessible, equitable and affordable as physical health services with parity of comprehensive coverage equivalent to physical health care. If the co-pay is 80/20 pay and no lifetime limits for physical health, it needs to be the same for mental health. This is incentive to consumer and provider to take care of body and mind in proper balance.

Second, shift the incentives from hospital-based to ambulatory-based systems of mental health care (e.g., no more 20 percent co-pay for hospital and 50 percent co-pay for ambulatory). This will encourage people to get appropriate care early and providers to use more cost-effective treatments.

Third, reward lasting outcomes instead of everlasting procedures. Instead of payments for units of time or procedures, our mental health benefits should pay for the most effective combinations of care that get results for the lowest total dollar. Either capitation or episode of care incentives focused on improved mental health outcomes will change the competition to getting the most improved health status for the dollar.

Fourth, reward organized systems of care that integrate and coordinate patient care for the best physical and mental health outcomes. We need teamwork incentives for private and public services networks, for integrated mental/physical healthcare in the family practitioner's office, in the health education department, in the emergency room and in the heart rehabilitation unit. The most expensive cases are the multiple problem cases where we need to cut cost by sharing care.

The Washington Business Group on Health has documented several businesses that have led the way in providing comprehensive mental health coverage, switching to ambulatory incentives, and rewarding mental health managed care. They have found that it pays.

For example, McDonnell Douglas has developed an employee assistance program with mental health benefits that "has no rules . . ., authorized treatment in a variety of inpatient, outpatient and intermediary settings based on individual needs . . ., and covers 80 percent of charges for approved network services regardless of treatment setting. During the first year, 17 percent of the covered population used benefits, up from 10 percent the previous year. At the same time, per capita costs declined by 34 percent. Reduced costs were attributed to a 50 percent decrease in psychiatric and a 29 percent decrease in chemical dependency admissions, a 47 percent decrease in average length of stay and lower provider payments through negotiated rates. The company also monitored patient satisfaction and found no complaints

from the 1,172 people who received treatment regarding quality, accessibility or quantity of care". First Chicago's experience with hospitalization alternatives since 1984 included day hospitalization, medication management and intensive outpatient programs covered at 85 percent. Over 6 years, they had significant decreases in the inappropriate use of hospitalization coupled with enhanced access to ambulatory mental health services which has resulted in total decrease in inpatient spending of 59 percent while total mental health expenditures increased by only 3 percent without coverage limits or benefit cuts at a time when U.S. mental health costs were increasing consistently with general medical hyperinflation. IBM, Chevron and Digital reported similar trends in cost savings through their switch to ambulatory and consumer needs based on mental health coverage.[5]

If Congress switches the incentives, I believe the focus of mental health care financing will switch from harvesting billings to competition for best care and outcome buys. Mental health care access, quality and outcomes will go up while relative costs and losses will go down over time. The sooner the switch, the better, so we do not accrue another 7 years of neglected care and its costs and losses.

Our time together does not allow adequate attention to be paid to the need to strengthen our mental health status and economy with increased opportunities for mental illness research, prevention, mental health promotion and long-term care reforms for all our disabled populations, but that is part of the big picture too.

Thank you again for the opportunity to testify. The board, staff and consumers I represent today know that you will influence the whole health debate for the better. We will appreciate all that you will do to improve mental health access, effectiveness and affordability in support of improved health, economy and quality of life for all Americans.

I have provided the sources and documentation for the information cited. Those sources are:

[1] "Mental Illness Touches 48 Percent in U.S.", Arkansas Democrat-Gazette, January 14, 1994, p. 3A.

[2] "New Perspectives on Mental Health Care in America" in "Eight Strategic Initiatives for a Cost-Effective Health System" monograph by David L. Williams, Steve Foti, and John Greer, Little Rock, January, 1993, p. 2.

[3] "New Perspectives," pp. 2-3.

[4] This is an adaption of recommendations found in the "Eight Strategic Initiatives (pp. 1 and 2) and two other documents: "Recommendations of the Little Rock Working Group on Mental and Substance Abuse Disorders," G. Richard Smith, M.D., and Barbara J. Burns, Editors, Little Rock, AR, February 3-5, 1994, p. 6, and "Board Responds to Clinton Plan" in National Council News, December, 1993, p. 5.

[5] Washington Business Group on Health in "Eight Strategic Initiatives", p. 5.

The CHAIRMAN. Thank you, David. I might say that your organization and mental health proponents are extremely well represented in Washington. They have very effective lobbyists.

I do not quite understand this co-payment proposal of the President's. To tell you the truth, it does not make much sense to me. I am quite sure that something will be done to change it in the process of going through amending the bill.

I have been out to a place in Washington that feeds the homeless. My son and daughter and I have been out there and flipped pancakes at breakfast for hours. I tried to visit with as many of those people as I could, and as you know, Washington has a very high percentage of homeless people.

We were told that a third of those people are employed, and some of them just do not make enough to afford an apartment or a place to live. But that a third of them really have mental problems. About a third of them have real mental problems and simply cannot function.

A lot of them, they tell me, were in institutions, and were sent home with a packet of medications, and told "When this is out, call us and we will replenish it for you." They just do not do it. So they go right back to where they came from.

What, if anything, do you think we ought to be doing about those homeless people who fall in that category?

Mr. WILLIAMS. I think you ought to be doing what we are doing in Arkansas, nationwide, and I think the benefit system and structure should be set up to reinforcement. I did not get to speak, just out of choice of time, about the need for this whole system to be complemented at both ends with good mental health prevention and mental health promotion research, and at the other end, with a good linkage with long-term care plans. I speak from the perspective of having 750 people with long-term, serious mental disorders in treatment in any given year, and many of those people have been homeless.

During cold spells like this last one, nowadays, I go around asking, "Has everybody got a warm place to sleep?" I can tell you 10 years ago everybody did not have one. Nowadays, about the most I have to authorize is maybe an electric blanket occasionally to make sure somebody is warm.

A number of those people have been brought into successful community support treatment programs. Basically, they are ambulatory based programs where what happens during the day is their home base is a rehabilitation center or call it a clubhouse, or a socialization center, call it what you will. They perform at the capacity that they can.

Then, what we have is community supports to keep them viable and okay in the community. In some cases, they live in apartments that we own; in some cases they live with parents or family members that are able to keep them at home, and keep them from being homeless, because they count on us to support them with everything from family education, to how to manage the disease, to being guaranteed on-call, round-the-clock counselors, case managers, physicians 24 hours a day, 365 days a year.

They have case managers who range from good public health nurses, social workers, who do everything from making house calls, and with the children, when they are recovering from a bad episode of care, going to the school to help them make it day in and day out. What people experience is a broad array of support, both social and medical, to maintain them at the highest level of functioning possible.

We need more of that. We need for our Social Security disability system, our health system, and our various social and educational support systems to be united around the patient in ways that these homeless people are really supported in being kept from being homeless. You will see fewer homeless people who are visible in northwest Arkansas because we tend to have a larger, more adequate system for more of these people than most places proportionate to the population. But there are a lot more that we ought to be serving. We think we are dealing with about half of them.

The whole Nation abandoned these folks when we did not have in place good organized systems to take the place of taking them out of the hospital.

The CHAIRMAN. Yes.

Mr. WILLIAMS. I think we do not need to do that, and that this system can be integrated in a way that we do not have to.

The CHAIRMAN. Dr. Proffitt, you are a part of the Area Health Educational Center here?

Dr. PROFFITT. Yes, sir.

The CHAIRMAN. Do you know Arkansas had a young, good looking, dynamic governor back in the 1970s who started that program?

Dr. PROFFITT. Yes, sir. I thank you very much. And we talk about it often.

The CHAIRMAN. Well, it has been a very big winner, has it not?

Dr. PROFFITT. Yes, sir, it has.

The CHAIRMAN. And, you know, I had to go to bat last year because of the funding. As you know, there was a proposal by the Bush Administration to cut back on the funding for AHECs.

Dr. PROFFITT. Yes, sir.

The CHAIRMAN. And, not only just because I started the program, but that was one of five things that we did in trying to improve primary health care delivery in this state. And it was not original with me, really. We sort of copied the North Carolina program, but Dr. Bose took it and really made it work.

Dr. PROFFITT. Right.

The CHAIRMAN. I have always been very proud of that. But I want to ask you all this question. We are getting ready to go through welfare reform this year.

The other night I was at an embassy party, and to tell you the truth I am not much of a socializer. This happened to be a charity event for an organization that Betty was involved in.

So I went, and I sat beside a doctor's wife who had the answer to everything. I mean, she should have had my seat in the Senate. I do not mind telling you, she got on my nerves. There was just no room for discussion. Everything she said was with such a degree of finality that there was no comeback, no chance to discuss it.

I listed three or four things that I thought had caused our health care costs to get out of control. She'd say, "No, that is not it. No, that is not it."

"What is it, then?"

"Well, it is all these welfare mamas having defective babies that cost 50 thousand to a million dollars. They are low birth weight babies, and you keep them in the preemies section, and that is what is causing health care costs in this country to go out of sight."

Well, you know, there is some truth to what she says, because that is a problem. But, you know, you get accused of being a liberal if you favor some of those social programs, and I happen to be a very strong proponent of the WIC program. If you want to make a moral judgment about a woman getting pregnant out of wedlock, that is fine, you can do that.

The WIC program has a three to one payback. Now, there are people who do not much like the so-called Women, Infants, and Children program, but the truth of the matter is if you get all the poor pregnant women into that program you will have a lot fewer defective babies, and you will measurably decrease health care costs in this country.

Now, you and I know that, particularly in the inner cities, and I know it is true in some of the poverty stricken areas of rural Arkansas, women often see a doctor for the first time for delivery. They have had no prenatal care, they have had no dietary instruc-

tions. And they may have a low birth weight baby, or they may have a baby defective in other ways because they have been smoking and drinking during the pregnancy.

But when it comes to welfare reform, which we are obviously going to address in some way this year, what would you do about the fact that the number of children being born out of wedlock continues to go up, going up faster among white mothers now than black mothers?

The numbers are about 900,000 white babies born a year, and 300,000 black babies a year being born out of wedlock, and we expect the crime rate to go down when we are producing 1,200,000 essentially unwanted, uncared for children. Not necessarily.

But, there is a correlation of children who are neglected, who are abused, and who are unwanted. And that is who is pulling the trigger at 14 and 15 years of age in Washington, New York, and Little Rock.

So my question is this: Would you penalize women who have a tendency to have a bunch of children out of wedlock in order to try to use a stick? Or would you use a carrot? For example, would you consider an amendment that somebody might offer regarding mothers having their second child out of wedlock when they have been on AFDC for 4 years.

Food stamps and AFDC were created because we made a conscious decision a long time ago that we did not want a child to go hungry in this country, and I subscribe to that.

Constitutionally we probably could not say, "If you do not have a Norplant or something we are not going to pay for any more children." But you could do this; you could say, "If you do not have any more children, we will raise your payments by $25 per child for the ones you have. If you do have any more, we are going to take that, plus another $25 away from you."

Now, people like Mrs. Clinton, Betty Bumpers and Marian Wright Edelman say that would be cruel. But, we have been so busy being politically correct in this country, we simply have not talked openly and candidly about the problem.

It is like an alcoholic. If you do not admit you are an alcoholic, you are not going to get any help. That is the first order of business, is it not? And it is the first order of business in this country to admit that we have a mammoth problem, and what are we going to do about it? What would you do?

Dr. PROFFITT. Well, I think if I knew that answer, you and I both could collect the Nobel Prize next year.

The CHAIRMAN. I am looking for one.

Dr. PROFFITT. I think, as I mentioned earlier, we have to have some education starting at some point that really tries to tackle the problem in the very beginning of why we have the problems, anyway. I think we can get into some really sensitive issues——

The CHAIRMAN. We are not going to solve this problem here this morning.

Dr. PROFFITT. No.

The CHAIRMAN. We are about finished up, and I do not want to get into a lengthy philosophical discussion on this.

Dr. PROFFITT. No.

The CHAIRMAN. But I am just saying it is a big problem, and it is a big problem for health care costs in this country.

Dr. PROFFITT. Exactly.

The CHAIRMAN. It is a big problem for social costs in the country. Medicaid has just sailed right out of sight. And virtually every one of these children we've talked about is Medicaid.

Dr. PROFFITT. My only answer, without having a long time to discuss this with you, is from what I see personally. I am an active practicing physician, and I practice not only in the AHEC clinic, but I also practice in an emergency room where I see things that go on. I also participate with the local health departments, and have been active in helping with maternal child issues.

And I find that there is so much misuse of the system, there is no way I can put costs or figures to that, it is just a personal revelation to you that the abuse of the system would probably more than pay for the reform we are talking about.

An instance was this past week, two couples came to the emergency room late at night, one an angry, ignorant 16-year-old white female with her husband.

The CHAIRMAN. Sixteen-year-old woman?

Dr. PROFFITT. A woman with a 2-month-old baby, and the baby did need medical care, there was no question. She was angry that she was not going to see a physician she thought she should see.

The other couple came with them were unmarried with the girl being pregnant. He came in for a minor illness, and he had no business coming in.

I came in to see the baby. I could not get a very good history from them as to what was going on, and I had to spend a lot of time myself with the baby trying to figure out what the problem was. While I was there, the four adults engaged in a conversation, totally oblivious to me trying to take care of the baby, talking about how they were on Medicaid, how they were going to continue to come to the emergency room for their care, discussing all the things that were things that I had been thinking about for a long time on what was wrong with the system.

I do not see any way you can change that problem. These people are not reachable at the point that they are right now. The only thing I know to do that is to prevent it from ever happening. I think there is a large population in this country who do not value health care, what we are here to talk about today. I do not think a large majority of people value their health care.

I think a lot of it results from ignorance, and I think that is why we have to have, some point, a sturdy health education program in our schools that teaches people about health and wellness, how to access the health care system, and to some degree, what is appropriate and inappropriate. I think just the basic level of knowing how to do that would really help us contain our cost.

I think a longitudinal program would be able to minimize these effects financially, and hopefully really promote the better health, which I think will last for a lifetime. We are talking about investing in babies who will live for perhaps 80 years, we are not talking about an 85-year-old man or woman who is on a respirator, who is going to live another day or another week or another month.

The CHAIRMAN. Kathy, are birth control pills available to all people on Medicaid?

Ms. JAGGERS. Yes, they are. And I think that is an answer. Let us prevent those pregnancies. Let us not let them occur.

The CHAIRMAN. Yes.

Ms. JAGGERS. It seems kind of ludicrous to me that I cannot go into a school system and teach about reproduction or family planning methods, but I can go in and do a maternity clinic. When I do go in to teach that maternity clinic to take care of those pregnant teenagers, I cannot discuss reproduction, fertility, or birth control methods.

The CHAIRMAN. You cannot, under state law or Federal law?

Ms. JAGGERS. Under the school board laws.

The CHAIRMAN. Oh, the local school board?

Ms. JAGGERS. Local school board laws. If we could educate these children, if we could talk about reproductive contraception, if we could have more outreach, get into the hospitals where these teenagers are delivering their babies. Before they go home to the hospital, let us teach reproduction, let us get them on a method of birth control.

For the ones who already have the babies, let us provide child care, education and training. But get us into the school systems, that is where we need to be, teaching this, preventing those pregnancies in the first place.

The CHAIRMAN. Kathy, I spoke at a high school graduation several years ago, and there were roughly 40 graduates in the class, and ten of the girls were pregnant. Now, the president of the school board, who was seated by me, told me this.

With some controversy, they established a school based health clinic to deal with precisely what you are saying you are not permitted to deal with. I went back there roughly 5 years later to speak, and there was the same number of graduates, but we had two, maybe three pregnant girls in that class. Now, you know, those clinics can be controversial. When Joycelyn Elders talks about school based clinics, everybody immediately assumes that all she wants to do is distribute condoms to everybody.

Ms. JAGGERS. On the lunch plates.

The CHAIRMAN. Yes. Now, you know, Betty is a product of having grown up in Grand Prairie, AR, and Charleston was a metropolis compared to where she grew up. But our principal health care—at least hers—was the county health nurse at the school.

We have a sort of running disagreement on this, because she is hot now on having a nurse practitioner or a clinic in every school in America. Not just for the students, though, she wants to make it available to the public, too. Have you heard of that concept?

Ms. JAGGERS. Yes, I have. I think it would work out wonderfully.

The CHAIRMAN. Do you?

Ms. JAGGERS. Yes.

The CHAIRMAN. Well, I am sorry to hear that. I have been disagreeing with her.

Ms. JAGGERS. But especially for the school children.

The CHAIRMAN. I think this is a sort of a rural issue, too. I think it would work much better in rural areas than it would in urban areas.

But I can tell you, and I told this story yesterday in Jonesboro at a hearing similar to this, that I had an amendment up late one night to say that AFDC mothers must get their children immunized, or within 3 months they lose their benefit. Maryland tried that, and moved their immunization levels of children on childhood preventable diseases from 48 to 92 percent. So do not tell me it will not work.

Well, Mrs. Clinton and Betty jumped all over me when I offered that amendment. They said, "This is terrible, this is cruel."

Well, I won. It is not mandatory. What we were doing is saying, "You states can have the authority to do this if you want to." But it works, and it is working. I do not know of anything that I have ever been prouder of, and I finally convinced Betty that it was a good idea. I do not think I have convinced Mrs. Clinton yet.

The point I am making is, I think that something like that could work for these unwed mothers who are having children. I know you sit around in the coffee shops and you hear this stuff. I am trying to deal with the real problem in a real way. And I am not saying that Norplant is the answer, but a woman may take her birth control pill and she may not. She may continue to have babies.

Where else is this happening? Maryland?

Ms. CHAFFEE. New Jersey.

The CHAIRMAN. New Jersey, a lot of states are saying, "When you get past the second baby, forget it." I do not know whether or not that is going to work.

I know there are cases of it, but as a rule, I do not think women have babies to get more money. I think they do it because they are essentially ignorant, nobody ever cared for them, nobody ever told them, and so it just becomes a way of life with them. But generally, what do you and Nancy think about it? We need to adjourn here pretty quickly, but just in a minute or less, Nancy, how do you feel about some sort of a mandatory thing?

As I say, you cut their payments. Somebody says, "Well, you are punishing the child." You might not be, because I think if you said to them, "Do not have any more children, we will raise your payments $25 per child," that is a real incentive not to have any more children, is it not? I promise you we would be a lot better off, monetarily; the government and the treasury would be a lot better off if we did that.

Ms. MARSH. Women like AFDC and Medicaid, the program that you are talking about, immunization, family planning, EPSDT screens, they are all offered.

But I think they ought to be mandated. I think if they are recertified for Medicaid every 6 months, and in that 6 months you have time to get everybody up to date on their physical exams, their immunizations, you need to attend a family planning clinic. I think, if we mandated those people to get into that, if they cannot get one or two children in there and themselves, then I think it brings back home they have got to take some responsibility for running that family.

The CHAIRMAN. Nancy, in the Maryland AFDC program that I mentioned a moment ago where you cut off payments if a woman did not comply and did not have her children immunized, they cut

her payments off. They took what she would have otherwise received and put it into other programs dealing with immunization or with AFDC.

I disagree with that. I think that money ought to be set aside, and if she knows that money is there, and that she can have it the minute she comes in and certifies her children to be immunized, she will do it. The minute she has an extraordinary expense, and she knows there is $1,000 in the pot down there that she can get by simply taking those children to get a free shot, she will do it. I do not believe in taking it away from them permanently, unless they just refuse to comply. And that is one of the things that, Betty and I had some difficulty with.

One other question, Kathy. You said something about having nurse practitioners in every clinic. Is that do-able?

Ms. JAGGERS. Yes, very do-able.

The CHAIRMAN. How many nurse practitioners are there in this state?

Ms. JAGGERS. There are over 4,000.

The CHAIRMAN. Now, wait a minute, are you including RNs in that, too?

Ms. JAGGERS. No.

Ms. MARSH. No.

Ms. JAGGERS. There are over 4,000.

The CHAIRMAN. Four thousand nurse practitioners?

Ms. JAGGERS. Practicing nurse practitioners. And there are more training programs now. There is a newly established training program for family nurse practitioners at UAMS in Little Rock.

The CHAIRMAN. I am really shocked at that.

Ms. JAGGERS. Yes.

The CHAIRMAN. There are 4,000 in Arkansas?

Ms. JAGGERS. Yes, 4,000.

The CHAIRMAN. See, that is the reason I hold these hearings. I learn so much.

Ms. MARSH. Well, a lot of them are like me, I am a practitioner, but I do not work as a practitioner. I use those skills and stuff, but when you are talking about there is being 4,000——

The CHAIRMAN. Now, you do not have a full-time physician in Huntsville?

Ms. MARSH. Right.

The CHAIRMAN. You have part-time from somebody in Fayetteville or where?

Ms. MARSH. Springdale hospital bought the clinic, and they hired physicians to staff that clinic. As of this time I think they do not all work full-time.

The CHAIRMAN. What is the population of Huntsville?

Ms. MARSH. Huntsville is around 1,300.

The CHAIRMAN. Well, I think you have answered most of my questions. We could sit here and talk about these things all day long, and I would love to do it, because it really is helpful to me. You have all been very helpful, and you have all spoken very eloquently and it has been extremely helpful to me. I want to thank you personally for the time you have taken to prepare your testimony and to come and be with us this morning.

We will stand adjourned.

[Whereupon, at 12:50 p.m. the hearing was adjourned.]
[Additional materials submitted for the record.]

PEL-FREEZ,
ROGERS, AR 72757,
January 20, 1994.

SENATOR DALE BUMPERS,
United States Senate,
Washington, DC 20510-0401.

DEAR SENATOR BUMPERS. Thank you for holding today's hearing on health care reform today here in Fayetteville. I ask that these written comments be included in the record.

Pel-Freez is a small business, headquartered in Rogers, with a focus on medical diagnostics and biotechnology. We are proud of our role as one of Arkansas's leading technology driven companies.

I support the process, already underway, of reforming the Nation's health care system. Being a founding member in 1992 of the Business Health Care Forum in Rogers, I have been involved in this reform issue for several years. My interest arose when our company experienced very high cost increases and lack of competitive quotes from the health "insurance" industry. I should note that Pel-Freez is now self-insured due to such problems within the "insurance" industry.

I would urge caution as you consider the various proposals now being offered in Congress. There is much right with America's health care system, and an economic sector comprising one-seventh of our gross domestic product should not be quickly restructured just for the sake of political benefit. The Federal Government's role should be very limited.

Our health care system is not in crisis. Efforts by the Federal Government to improve access are important, as all Americans should be able to receive health care coverage. However, we do not need to set in motion laws and regulations which will cause a decline in the quality of American medicine and in the right of Americans to continue their established patient doctor relationships. Small business should not be forced to offer health insurance.

Further, price controls should not be a part of the Federal reform effort. We should work within the free enterprise markets, not run to price controls as an answer. The recent letter to the Wall Street Journal, copy attached, from over 500 economists, decrying price controls in health care, states clearly the defects in proposed controls.

I urge you to consider those legislative concepts which would enhance the American health care system without imposing massive new Federal laws, regulations, and bureaucracies. I ask you to think about the following concepts:

Reform insurance markets to make health insurance stable and portable.
Limit pre-existing-condition restrictions under employer health plans.
Eliminate barriers to small-business insurance pools.
Lower insurance premiums by making them tax deductible.
Permit the establishment of medical savings accounts.
Reduce costs through malpractice reform.
Simplify health care paperwork through administrative reforms.
Reduce Medicaid and Medicare expenses by lifting the regulatory burden on States.
Provide health insurance tax credits or vouchers to low-income families.

Pel-Freez is being affected by the impact of the proposed Federal health care reform package on our capital markets. Our company relies upon the ability of our customers and ourselves to readily raise capital to fund new product development and plant expansion. Today we are holding back on expansion plans, hiring, and start up of new R&D programs.

We ask for your help in removing breakthrough drug price review and HHS Medicare drug price review/black listing from any Federal health care reform package. These provisions have had a huge affect on the capital markets for biotech and health care companies. Your efforts will make a difference, just as you did in the modification of the capital gains taxes as applied to small business.

Thank you for considering these remarks.

Sincerely,

DAVID W. DUBBELL,
President, Pel-Freez, Inc.

JAN-21-1994 08:53 FROM PEL-FREEZ TO D. DUBBELL (H) P.01
THE WALL STREET JOURNAL FRIDAY, JANUARY 14, 1994

Dear Mr. President . . .

In 1930, 1,028 economists foresaw the Depression in a letter they sent President Herbert Hoover warning against the Smoot-Hawley Tariff Act. Today we print a similar letter—along with the names of some of its 562 signatories—warning against the economic consequences of the Clinton health care plan.

January 13, 1994

Dear President Clinton:

Price controls produce shortages, black markets and reduced quality. This has been the universal experience in the 4,000 years that governments have tried to artificially hold prices down using regulations.

You insist that your health care plan avoids price controls. We respectfully disagree. Your plan sets the fees charged by doctors and hospitals, caps annual spending on health care, limits insurance premiums, and imposes price limitations on new and existing drugs.

In countries that have imposed these types of regulations, patients face delays of months and years for surgery, government bureaucrats decide treatment options instead of doctors or patients, and innovations in medical techniques and pharmaceuticals are dramatically reduced. Here in America, the threat of price controls on medicines has already decreased research and development at drug companies, which will lead to reduced discoveries and the loss of life in the future.

In the 1970s, government tried to regulate the price of a simple homogenous product, gasoline. The result was a social and economic disaster. People were forced to waste hours waiting in lines to purchase gasoline. Long waits for surgery and other medical care will have far more serious consequences.

Caps, fee schedules and other government regulations may appear to reduce medical spending, but such gains are illusory. We will instead end up with lower-quality medical care, reduced medical innovation, and expensive new bureaucracies to monitor compliance. These controls will hurt people, and they will damage the economy. We urge you to remove price controls, in any form, from your health care plan.

Armen A. Alchian UCLA
Wayne Allen Delta State University
William R. Allen UCLA
Gary M. Anderson California State University at Northridge
Martin Anderson Hoover Institution, Stanford University
John Baden University of Washington
Samuel H. Baker College of William & Mary
R. Robert Batemarco Manhattan College
Arleigh T. Bell Jr. Loyola College in Maryland
Ernst R. Berndt Massachusetts Institute of Technology
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